MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2018 — Reg. Dist. No. 01990

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 30 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BETHESDA
d. STREET ADDRESS: 5614 OAK PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WINBERN — Middle C. — Last ADCOCK
4. DATE OF DEATH: Month 2 — Day 17 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-1-78
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): TENN.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Adcock
14. MOTHER'S MAIDEN NAME: NANNIE PARRISH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): SPANISH AM.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Francis N. Adcock — Address: SON. 3517 RHEM RD. Balto 7, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE) (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 wks
DUE TO (b) Arteriosclerosis — Progressive
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1952 to Feb 1952, that I last saw the deceased alive on Feb 16 1959, and that death occurred at 5:30 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: L. I. Donovan M.D. — ADDRESS (Street, city or town, state): 5016 Wenzlton Rd — DATE SIGNED: 2/17/59
PHYSICIAN'S NAME (Type): LEO I DONOVAN M.D. — Bethesda 14 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2/20/59
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE: A H Hines Co — ADDRESS: 2901 14th NW
24a. REC'D BY REGISTRAR: DATE FEB 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2019

Reg. Dist. No. 00748

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN Ib: 116 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville 1615
d. STREET ADDRESS: 5812 Sargent Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: Michael — Last: Alexander

4. DATE OF DEATH: Month: February — Day: 1, — Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: March 2, 1950
9. AGE (In years last birthday): 8 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wilmer ~~Wilson~~ Alexander
14. MOTHER'S MAIDEN NAME: Raffella Melina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Adrenocortical Carcinoma, Metastatic — INTERVAL BETWEEN ONSET AND DEATH: 8 mos
195.0
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 8, 1958, to February 1, 1959, that I last saw the deceased alive on February 1, 1959, and that death occurred at 3:10 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore L. Goodfriend M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 2-1-59

PHYSICIAN'S NAME (Type): Theodore L. Goodfriend, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-3-59
22c. NAME OF CEMETERY OR CREMATORY: Ft. Linclon Cemetery
22d. LOCATION (City, town, or county) (State): Bladensburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: F. J. Collins — ADDRESS: WASH. D.C.
FRNACIS J. COLLINS 3821 14TH. ST. N.W.
24a. REC'D BY REGISTRAR DATE: FEB 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2020 **CERTIFICATE OF DEATH** Reg. Dist. No. 01991

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 60 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kensington
d. STREET ADDRESS: 4104 Dresden Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Relyea Last: Appleman
4. DATE OF DEATH: Month: February Day: 13, Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 14, 1924
9. AGE (In years last birthday): 34 yrs. IF UNDER 1 YEAR: Months / Days / IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Air Conditioning Installer
10b. KIND OF BUSINESS OR INDUSTRY: Air Conditioner
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lawrence V. Appleman
14. MOTHER'S MAIDEN NAME: Margaret Cogan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Hodgkin's Disease

201X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 15, 1958 to February 13, 1959, that I last saw the deceased alive on February 13, 1959, and that death occurred at 5:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Richard Lee M.D. M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2/13/59
PHYSICIAN'S NAME (Type): G. Richard Lee, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/13/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey-Bethesda, Md. ADDRESS
24a. REC'D BY REGISTRAR DATE FEB 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) ISM 9/55

1

2021

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01992

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 74 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 16x-2
d. STREET ADDRESS: 601 Southern Avenue, S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

50

3. NAME OF DECEASED (Type or print): First: Monda — Middle: Aliene — Last: Aycoth
4. DATE OF DEATH: Month: February — Day: 6th, — Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: June 24, 1915
9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Automobile
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Ashe
14. MOTHER'S MAIDEN NAME: Lula Rodgers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-30-4077
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Malignant Melanoma Metastatic to Heart — INTERVAL BETWEEN ONSET AND DEATH: 3 Months
190.9
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 24, 1958 to February 6, 1959, that I last saw the deceased alive on February 6th, 1959, and that death occurred at 7:05A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Richard Lee M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 2/6/59

PHYSICIAN'S NAME (Type): G. RICHARD LEE, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): 2/9/59
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. Wm Lee's Sons Co — ADDRESS: 300 4th st Nw Wash 2 DC. N.E.
24a. REC'D BY REGISTRAR: DATE FEB 10 '59
24b. REGISTRAR'S SIGNATURE: William E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2022 CERTIFICATE OF DEATH

Reg. Dist. No. 01993

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

7. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Northampton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seaview
d. STREET ADDRESS: (None)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn Middle: Claudia Last: Bailey
4. DATE OF DEATH: Month: February Day: 21 Year: 1959
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 25, 1936
9. AGE (In years last birthday): 22 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Worker
10b. KIND OF BUSINESS OR INDUSTRY: Labor (Private)
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Elijah Collins
14. MOTHER'S MAIDEN NAME: Alberta Gillis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 230-48-1931
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
443X
DUE TO (b) Uremia — 4 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Hypertensive Cardiovascular Disease — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 18, 1959, to February 21, 1959, that I last saw the deceased alive on February 21, 1959, and that death occurred at 10:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis Gillespie, Jr. M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2/22/59
PHYSICIAN'S NAME (Type): LOUIS GILLESPIE, JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 28, 1959
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county): Arlington (State): Va
23. FUNERAL DIRECTOR'S SIGNATURE: James E. Chum
ADDRESS: Arlington Va
24a. REC'D BY REGISTRAR DATE: FEB 24 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Ltr # 20 Film 245 [illegible] ams

1987 **CERTIFICATE OF DEATH**

Reg. Dist. No. 00749

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
5 LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 2712 Spencer Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Annie; Middle: Eliza; Last: Bean
4 DATE OF DEATH: Month: February; Day: 2; Year: 1957

5 SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: July 15, 1867
9 AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months: 6; Days: 17
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Edward Johnston
14 MOTHER'S MAIDEN NAME: Ann E. Warfield

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: None
17 INFORMANT: Washington Sanitarium & Hosp. Records — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSE BY IMMEDIATE CAUSE (a): [illegible] — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

DUE TO (b): [illegible]

DUE TO (c): [illegible]

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: 104.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): [illegible]

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify Medical Examiner):
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): [illegible]

20c TIME OF INJURY: Month: [illegible]; Day: [illegible]; Year: 19[illegible]; Hour: [illegible] a.m. p.m.
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): [illegible]
20f (City or town): [illegible] (County): [illegible] (State): [illegible]

21. I certify that I attended the deceased from [illegible] 19[illegible] to [illegible] 19[illegible], that I last saw the deceased alive on Feb 2, 19[illegible], and that death occurred at 3:[illegible] P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] MD — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED: [illegible]

PHYSICIAN'S NAME (Type): Walter K. Angevine

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2/5/59
22c NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
22d LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphreys — ADDRESS: 1357 Ulsa Avenue
24a REC'D BY REGISTRAR: DATE FEB 5 59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9 55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1988 — 1994

Reg Dist No

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Burtonsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: William Middle: O. Last: Beasley
4. DATE OF DEATH: Month 2 Day 16 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-14-86
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Sight Seeing Guide
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Eduard Thomas Beasley
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Kenneth W Beasley - Son Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Collapsed in auto while driving
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH?
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury if Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-16-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/19/59
22c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
22d. LOCATION (City, town, or county) (State): Burtonsville, Md
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: DeWitt Donaldson, Laurel, Md
24a. RECEIVED BY REGISTRAR: DATE FEB 20 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A 5ME
5M 7/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2023

(199)

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tu Huseda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Tubenbaum

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3900 HAMPDEN ST.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mar Ha Middle: Lucretia (Mrs) Blanchard
4. DATE OF DEATH: Month 2 Day 16 Year 1959
5. SEX: F
6. COLOR OR RACE: Colored
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9/1/04
9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Amos King
14. MOTHER'S MAIDEN NAME: Margaret Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robert J. King Address: 307 Big Pipe Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Acute gastroenteritis
DUE TO
(b): Hypertensive cardiovascular disease
DUE TO
(c): and benign neoplasm of uterus

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE _____ M.D. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

PHYSICIAN'S NAME (Type) _____

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/21/59
22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial,
22d. LOCATION (City, town, or county) (State): Sandy Spring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Wood ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE FEB.
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A 5 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2024

Reg. Dist. No. 195

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN this place: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 501 Bonifant St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 501 Bonifant St.
DID DECEASED DIE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Craig Middle: Lee Last: Boley
4. DATE OF DEATH: Month: Feb. Day: 27, Year: 1959 19
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/20/1948
9. AGE (in years, last birthday): 10 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wm. J. Boley
14. MOTHER'S MAIDEN NAME: Dorothy V. Anderson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wm/ J. Boley Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory
5 / X
DUE TO (b) Cerebral palsy
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
DUE TO (c)
(In this space enter the circumstances of death) Found dead in bed. life

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ No while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/27/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/2/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

V5 A75ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2025 CERTIFICATE OF DEATH

Reg. Dist. No. 1954

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney

c. LENGTH OF STAY IN 1b: 5 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery Co. Gen. Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Clagettsville

d. STREET ADDRESS: RFD # 3, Mt. Airy

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Susie Middle: Viola Last: Bolton

4. DATE OF DEATH Month: Feb. Day: 16 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 13, 1891

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Potomac, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James L. Magruder

14. MOTHER'S MAIDEN NAME: Frances Ann Mullican

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Mrs Raymond Justice, Mt. Airy, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Cardiovascular-Renal Disease with	12 years
DUE TO (b)	Hypertension. Terminal Congestive Heart Failure. Uremia. Pulmonary Edema.	1 month 3 days.
DUE TO (c)		

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (If either, notify Medical Examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 11, 1950, to Feb. 16, 1959, that I last saw the deceased alive on Feb. 16, 1959, and that death occurred at 7 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: M. McKendree Boyer M.D.

PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.

ADDRESS (Street, city or town, state): 9830 Main Street, Damascus, Maryland.

DATE SIGNED: 2/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 19, 1959

22c. NAME OF CEMETERY OR CREMATORY: Rockville Union

22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth

ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR DATE: FEB 20 59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2026 **CERTIFICATE OF DEATH**

Reg. Dist. No. 01998

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

7 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Lebanon
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beirut
d. STREET ADDRESS: P.O. Box 2648
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michelle; Middle: Christine; Last: Braafladt
4. DATE OF DEATH: Month: February; Day: 13; Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 3, 1950
9. AGE (In years last birthday): 8 yrs.
If UNDER 1 YEAR OR UNDER 24 HRS.: Months | Days | Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Casablanca, Morocco
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: James Braafladt
14. MOTHER'S MAIDEN NAME: Yvette Bouchier
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Lymphocytic Lymphoma — INTERVAL BETWEEN ONSET AND DEATH: 10 months
DUE TO
(b)
DUE TO
(c)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 5, 1959 to February 13, 1959 that I last saw the deceased alive on February 13, 1959, and that death occurred at 10:25 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Nathan S. Taylor M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2-13-59
PHYSICIAN'S NAME (Type): Nathan S. Taylor, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 2-17-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington Memorial
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: C. P. Lorne
ADDRESS:
24a. REC'D BY REGISTRAR: DATE FEB 16 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2027 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg Dist No 1999

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c LENGTH OF STAY IN 1b: 17 yrs

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 208 St Lawrence Dr

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission): a STATE: Md b COUNTY: Monty c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring d STREET ADDRESS: 208 St Lawrence Dr

INSIDE CITY LIMITS? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Eva, Middle Frances, Last Bright

4 DATE OF DEATH: Month Feb, Day 14, Year 1957

5. SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 2-24-09

9 AGE In years last birthday: 49 yrs

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b KIND OF BUSINESS OR INDUSTRY: Maintenance Service Co.

11 BIRTHPLACE (State or foreign country): N.C.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Ben Anderson

14 MOTHER'S MAIDEN NAME: Eva Sargent

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16 SOCIAL SECURITY NO: 577-03-7928

17 INFORMANT: Mary Bright (daughter) Address: Stem 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration

DUE TO

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wound thru skull

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Self inflicted bullet wound

20c TIME OF INJURY: Hour 8:10 a.m. p.m., Month Feb, Day 14, Year 1957

20d INJURY OCCURRED: While at work ☐ Not while at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town) Silver Spring (County) Monty (State) Md

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and my opinion as to death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-14-57

EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a BURIAL CREMATION REMOVAL (Specify): BURIAL

22b DATE THEREOF: 2/16/59

22c NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY

22d LOCATION (City, town or county) (State): WASHINGTON, D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible]

24a RECEIVED BY REGISTRAR DATE: FEB 1 '55

24b REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in part in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

U.S. A. SMEE SM 2 57

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2028

CERTIFICATE OF DEATH

Reg. Dist. No. 1200

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN (b): 11 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rock Creek Foundation
d. STREET ADDRESS: 2112 Columbia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

3 NAME OF DECEASED (Type or print): First: Gertrude — Middle: Oberly — Last: Bright

4 DATE OF DEATH: Month: 2 — Day: 11 — Year: 1959

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: May 25, 1885

9 AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months — Days. IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): U.S.A. Ohio

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: John Henry Oberly

14 MOTHER'S MAIDEN NAME: Virginia Stuckers

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: ?

17 INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE) (a): Bronchio-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Arterio-Sclerotic Heart Disease — 4 years

DUE TO (c): Senility

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month — Day — Year — Hour — a.m. p.m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from March 2, 1958 to Feb. 19, 1959, that I last saw the deceased alive on Feb. 18, 1959, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. — ADDRESS (Street, city or town, state): Gaithersburg — DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): J.W. Bird — Sandy Spring, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2/23/59

22c NAME OF CEMETERY OR CREMATORY: Rock Creek Cem.

22d LOCATION (City, town, or county): Washington — (State): D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]

24a RECORD BY REGISTRAR — DATE:

24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A 5 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2029 **CERTIFICATE OF DEATH** Reg. Dist. No. 2001

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6008 Walhonding Rd. Glen Echo Hgts.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: 6008 Walhonding Road Washington 16, D. C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ida Middle: Belle Last: Buck
4. DATE OF DEATH: Month: Feb. Day: 5 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 10 1875
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Bland Co. Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Martin Jefferson Robinett
14. MOTHER'S MAIDEN NAME: Rebecca Elizabeth Shannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Walter Lee Williams Address: 6008 Walhonding Road, Glen Echo Heights, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours.

DUE TO (b) Generalized arteriosclerosis — years

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year
20d. INJURY OCCURRED: While at work ☐ While not at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 18 1959, to Feb. 5 1959, that I last saw the deceased alive on Feb. 5 1959, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C P Ryland M.D. ADDRESS (Street, city or town, state): 4400-49 St NW. DATE SIGNED: 2-6 59

PHYSICIAN'S NAME (Type): C.P. RYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/8/59
22c. NAME OF CEMETERY OR CREMATORY: West End
22d. LOCATION (City, town, or county) (State): Wytheville Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. N. Hopkins ADDRESS: Arlington Funeral Home 3901 North Fairfax Drive, Arlington, Virginia
24a. RECORDED BY REGISTRAR: Date FEB 9 1959
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician on
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for Files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02002

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN (b): Several hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Armory

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10,106 Georgia Avenue
e. SAME AS ABOVE: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Platt Last: Bull Sr.
4. DATE OF DEATH: Month: Feb. Day: 22 Year: 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 10, 1890
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Garfinkel's Dept. Store
11. BIRTHPLACE (State or foreign country): Newburg, New York
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13. FATHER'S NAME: Daniel Platt Bull
14. MOTHER'S MAIDEN NAME: Carrie Toleman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — If yes, give war or dates of service:
16. SOCIAL SECURITY NO.: 168-26-7391 D63-12-6521
17. INFORMANT: Mrs. Ella F. Bull, Silver Spring, Md. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c.)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — Interval between onset and death: sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: History of previous heart desease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month Day Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) State.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/22/59
NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Feb. 24, 1959
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Prince George's County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. Raymond C. Fiska — Silver Spring, Md.
24a. REC'D BY REGISTRAR: DATE FEB 25 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2031

CERTIFICATE OF DEATH

Reg Dist. No 02003

1

PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY

c. LENGTH OF STAY IN 1b: 20 min NB

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL

d. STREET ADDRESS: AVERY ROAD

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DAVID Middle: LESTER Last: BUTT

4. DATE OF DEATH: Month: FEBRUARY Day: 14 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/14/59

9. AGE (In years last birthday): yrs

If UNDER 1 YEAR: Months | Days | If UNDER 24 HRS: Hours | Minutes

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: PRESTON EUGENE BUTT

14. MOTHER'S MAIDEN NAME: CATHERINE PAULINE CROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: HOSPITAL RECORDS Address: OLNEY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congenital Volvulus — INTERVAL BETWEEN ONSET AND DEATH

756.2

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEB. 14, 1959 to FEB. 14, 1959, that I last saw the deceased alive on FEB. 14, 1959, and that death occurred at 3:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): A.D. BONIFANT, M.D. SANDY SPRING, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/18/59

22c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery

22d. LOCATION (City, town or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: FEB

24b. REGISTRAR'S SIGNATURE: Maud

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2032

CERTIFICATE OF DEATH

02104

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN this place: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1130 S. 16th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Berton; Middle: Johnson; Last: BYERS

4. DATE OF DEATH: Month: February; Day: 4; Year: 1959

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-21-10

9. AGE (In years last birthday): 48 yrs

If UNDER 1 YEAR: Months: ; Days: ; If UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Clinton BYERS

14. MOTHER'S MAIDEN NAME: Mary Frances HUTCHINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): 1927 to 1959

16. SOCIAL SECURITY NO.: 420-52-5087

17. INFORMANT: (W) Agnes Marie Byers, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): Pulmonary [illegible]
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: [illegible]

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month; Day; Year; Hour a. m. p. m.

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 3, 1959, to February 4, 1959, that I last saw the deceased alive on February 4, 1959, and that death occurred at 11:03 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC
DATE SIGNED: 2-5-59

PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN — Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-9-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Adams Funeral Home, 4740 Wisc. Ave. NW, Washington, D.C.

24a. REC'D BY REGISTRAR: DATE FEB 6 '59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2033 **CERTIFICATE OF DEATH** Reg. Dist. No. 12015

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

d. STREET ADDRESS 9603 - Falls Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Addie Middle J. Last Caldwell

4 DATE OF DEATH Month Feb Day 8 Year 1957

5. SEX F 6. COLOR OR RACE White 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Oct. 15, 1881 9 AGE (In years last birthday) 77 yrs.

F UNDER 1 YEAR Months 3 Days 13 F UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home

11 BIRTHPLACE (State or foreign country) Ill. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James F. Jackson 14 MOTHER'S MAIDEN NAME Sarah Ann Icling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO None 17 INFORMANT Mrs. Sidney A. Peters - Sister Address 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSE BY IMMEDIATE CAUSE (a) Cerebral vascular failure. INTERVAL BETWEEN ONSET AND DEATH 3 hrs

DUE TO (b) Arteriosclerotic heart disease 5 yrs

DUE TO (c)

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchiectasis, Diverticulosis, Chronic St

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Feb 1, 1957, to Feb 8, 1957, that I last saw the deceased alive on Feb 7, 1957, and that death occurred at 6 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE Earl H. Mitchell MD ADDRESS (Street, city or town, state) 2029 Q St N.W. Wash DC DATE SIGNED

PHYSICIAN'S NAME (Type) Earl H. Mitchell 2029 "Q" Street, N.W., Washington, D.C.

22a BURIAL CREMATION REMOVAL Specify Bur.-Transit 22b. DATE THEREOF 2/10/59 22c NAME OF CEMETERY OR CREMATORY Memorial Park 22d LOCATION (City, town, or county) (State) St. Petersburg, Florida

23 FUNERAL DIRECTOR'S SIGNATURE Robert W. Dunphy ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR DATE FEB 11 '59 24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A 5 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2034 **CERTIFICATE OF DEATH**

Reg Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva
d. STREET ADDRESS: - - - - - -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Edgar — Middle: Edwin — Last: CALDWELL

4 DATE OF DEATH: Month: February — Day: 23 — Year: 1959

5 SEX: Male

6 COLOR OR RACE: Caucasian

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8-20-92

9 AGE (In years last birthday): 66 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b KIND OF BUSINESS OR INDUSTRY: U.S.Navy

11 BIRTHPLACE (State or foreign country): Iowa

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William R. Caldwell

14 MOTHER'S MAIDEN NAME: Laura Adele Whitney

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Yes — (If yes, give war or dates of service): WWI & WWII

16 SOCIAL SECURITY NO: 212-28-1620

17 INFORMANT: (W) Mary Agnes Caldwell, same as #2 above — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4-6 mos.
162.1
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from February 6, 1959, to February 23, 1959, that I last saw the deceased alive on February 21, 1959, and that death occurred at 12:25 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: J. T. Horgan M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital — DATE SIGNED: 2-24-59

PHYSICIAN'S NAME (Type): J. T. HORGAN LCDR MC USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2-26-59

22c NAME OF CEMETERY OR CREMATORY: Annapolis National

22d. LOCATION (City, town, or county): Annapolis — (State): Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Edward A. Taylor — ADDRESS: John M. Taylor & Sons, Annapolis, Md.

24a. RECEIVED BY REGISTRAR: DATE FEB 26 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A75 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2035

Reg Dist No 12061

PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN b: 8 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 10112 Pierce Dr

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10112 Pierce Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Althea Middle: Pearl Last: Campbell
4. DATE OF DEATH: Month: Feb Day: 5 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-1-1891
9. AGE (If years, last birthday): 67 yrs
IF UNDER 1 YEAR: Months | IF UNDER 24 HRS: Days | Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm A. Easterday
14. MOTHER'S MAIDEN NAME: Cora Parson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: John J. Campbell Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary occlusion
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: History of previous heart disease for several years
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month Day Year; Hour a.m. p.m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-5-59

EXAMINER'S NAME (Type): FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/9/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county): Washington, D.C. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St., N.W. Washington, DC
24a. REC'D BY REGISTRAR: DATE FEB 9 1959
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please write the word "pending" in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A SME
RM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Uremia **2036** **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitarium

7 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chevy Chase
d. STREET ADDRESS: 3703 Thornapple Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Gordon — Middle: E. — Last: Canaga
4 DATE OF DEATH: Month: Feb — Day: 26 — Year: 1959
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct 21, 1882
9 AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months: 4 — Days: 5
IF UNDER 24 HRS: Hours — Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Ohio
12 CITIZEN OF WHAT COUNTRY? U S
13 FATHER'S NAME: Unknown
14 MOTHER'S MAIDEN NAME: Unknown
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16 SOCIAL SECURITY NO: Yes-Unknown
17 INFORMANT: Mary L. Canaga-wife-same as 2d — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Uremia, cause of — INTERVAL BETWEEN ONSET AND DEATH: Concurrent
DUE TO (b) Infarct Cerebrum
DUE TO (c) Cerebrovascular generalized — 5 yrs +

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemiplegia, right, sev. 2 mos.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1950 to Feb 26, 1959, that I last saw the deceased alive on Feb 25, 1959, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stewart Clapp M.D. — ADDRESS (Street, city or town, state): 3921 Ingomar St NW Wash 15 D.C. — DATE SIGNED: 2-26-59

PHYSICIAN'S NAME (Type): Stewart Clapp

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2/28/59
22c NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d LOCATION (City, town, or county) (State): Rockville, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a RECORD BY REGISTRAR: DATE MAR 4 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit Then please remove carbon papers Pages 3 and 2 should be filed with the registrar prior to burial cremation or removal and in any event within 72 hours after death

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2037

CERTIFICATE OF DEATH

Reg. Dist. No. 12109

1 PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL, INC.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GAITHERSBURG
d. STREET ADDRESS: RT. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: JASPER Middle: LEE Last: CANFIELD
4 DATE OF DEATH: Month: FEBRUARY Day: 25 Year: 19 59
5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 10/2/70
9 AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): WEST VIRGINIA
12 CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: Unknown
14 MOTHER'S MAIDEN NAME: Unknown
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17 INFORMANT: HOSPITAL RECORDS Address: OLNEY, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO (b) Hypertensive Arteriosclerotic
DUE TO (c) Gangrene.

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 1955, 19, to 2/25, 1959 that I last saw the deceased alive on 2/25, 1959, and that death occurred at 2:40P M, from the causes and on the date stated above

ACTUAL SIGNATURE: L. L. Leal M.D. ADDRESS (Street, city or town, state): Gaithersburg, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): L. L. LEAL, M. D. GAITHERSBURG, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-28-59
22c. NAME OF CEMETERY OR CREMATORY: Hiney Cemetery
22d LOCATION (City, town, or county) (State): Linn, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber ADDRESS: Laytonsville, Md.
24a. RECEIVED BY REGISTRAR: MAR 2 59
24b REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2039

CERTIFICATE OF DEATH

02010

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN (b): 56 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 1406 Allison Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: Francis — Last: CARMODY

4. DATE OF DEATH: Month: February — Day: 7 — Year: 1959

5 SEX: Male — 6. COLOR OR RACE: Caucasian — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-19-76

9 AGE (In years last birthday): 82 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b KIND OF BUSINESS OR INDUSTRY: U.S. NAVY

11 BIRTHPLACE (State or foreign country): IRELAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Timothy CARMODY

14 MOTHER'S MAIDEN NAME: Mary Ann ALLMAN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1892 to 1926

16. SOCIAL SECURITY NO.:

17 INFORMANT: Mary C. CARMODY — Address: 1406 ALLISON STREET N.W.D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from December 12, 1958, to February 7, 1959, that I last saw the deceased alive on February 7, 1959, and that death occurred at 1:14 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: John Ward Davis — M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital NNMC, Bethesda, 14 Maryland — DATE SIGNED: 2-8-59

PHYSICIAN'S NAME (Type): J.W. DAVIS LT MC USN

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2-11-59

22c NAME OF CEMETERY OR CREMATORY: Arlington National

22d LOCATION (City, town, or county): Arlington — (State): VA.

23 FUNERAL DIRECTOR'S SIGNATURE: S.H. HINES — ADDRESS: 2901 14th Street N.W. Washington, D.C.

24a REC'D BY REGISTRAR: DATE FEB 10 59

24b REGISTRAR'S SIGNATURE: Arthur L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2039 CERTIFICATE OF DEATH

Reg Dist No 0201 i

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: - - - - - -
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): 3522 Raymond Street

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3522 Raymond Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MODENIA — Middle M. — Last CHESTER

4 DATE OF DEATH: Month Feb. — Day 20 — Year 1959

5 SEX: Female — 6 COLOR OR RACE: White — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8 DATE OF BIRTH: April 9, 1865 — 9 AGE in years (last birthday): 93 yrs — IF UNDER 1 YEAR: Months 10, Days 11 — IF UNDER 24 HRS: Hours, Min

10a US ALL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: - - - - - -
11 BIRTHPLACE (State or foreign country): Kentucky
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph I. Dunn
14 MOTHER'S MAIDEN NAME: Mildred Craigg

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO: None
INFORMANT: Clay G. Walker — Address: as above #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebro-Cerebral Infarction
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 2 years

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Dec 1 1958 to Feb 20 1959 that I last saw the deceased alive on Feb. 19 1959 and that death occurred at 12:45 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Charles J. Brady M.D. — ADDRESS (Street, city or town, state): 35 Sligo Ave. — DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): J. Chester Frady, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial-Trans.
22b DATE THEREOF: 2-23-59
22c NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cem.
22d LOCATION (City, town, or county) (State): Calloway Co., Kentucky

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda 14, Md.
ADDRESS
24a. RECEIVED BY REGISTRAR: DATE FEB 25 '59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, removal or removal and in any event within 72 hours after death.

VS A 5 (4)
FSM 9 58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2040 **CERTIFICATE OF DEATH** Reg Dist. No 00750

PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRLAND

c. LENGTH OF STAY IN this place: 1-31-57-2-1-59

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: FAIRLAND NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: MARYLAND b. COUNTY: MONT.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. STREET ADDRESS: 711 Orchard Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary Middle Ellen Last CLARK

4. DATE OF DEATH: Month 2 Day 7 Year 1959

5. SEX: F

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 3-1876

9. AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Eli Ball Stokes

14. MOTHER'S MAIDEN NAME: Mildred Bessie Stokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs E. L. Bonch Address: 711 Orchard Rd. Sil. Spg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, thrombosis — 15 Mos.

DUE TO (b) Cerebrovascular accidents — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 19 57, to Feb, 19 59, that I last saw the deceased alive on Feb 25, 19 59, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. ADDRESS (Street, city or town, state): Silver Spring Md. DATE SIGNED: 2/7/59

PHYSICIAN'S NAME (Type): A. D. Bonifant

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 2/4/59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible] Washington, D.C.

24a. REC'D BY REGISTRAR DATE FEB 5 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2041 — Reg. Dist. No. 2112

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRLAND
c. LENGTH OF STAY IN 1b: 2/11/59 - 2/26/59
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAIRLAND NURSING HOME

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY: Atlantic
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Atlantic City N. J.
d. STREET ADDRESS: 140 So. Rhode Island Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CECELIA — Middle — Last COHEN
4. DATE OF DEATH: Month 2 — Day 26 — Year 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-18-1894
9. AGE (Last birthday): 64 years
If UNDER 1 YEAR: Months — Days
If UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): AUSTRIA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: SIMON PFEFFER
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Carl Golden — Address: 3208 Falmouth St., Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Gallbladder with
DUE TO (b) metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 11, 1959 to Feb. 26, 1959, that I last saw the deceased alive on Feb. 25, 1959, and that death occurred at 12:25 M from the causes and on the date stated above.

ACTUAL SIGNATURE: Boris Rabkin M.D. — M.D. — ADDRESS (Street, city or town, state): 1019 University Boulevard — DATE SIGNED: Feb. 26, 1959
PHYSICIAN'S NAME (Type): BORIS RABKIN — Silver Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-27-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Sharon Cem.
22d. LOCATION (City, town or county) (State): Springfield Twp. Del. Co. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Wagner E. Funeral Dir. — ADDRESS: 8431 Georgia Ave. Silver Spring Md.
24a. REC'D BY REGISTRAR: DATE FEB 27 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No 215

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN this place: 6 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Pennsylvania — b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia

d. STREET ADDRESS: 1249 N. 2nd Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Daniel — Middle: Forest — Last: COLLINS II

4 DATE OF DEATH: Month: February — Day: 26 — Year: 1959

5 SEX: Male

6 COLOR OR RACE: Caucasian

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 1-19-39

9 AGE (years, last birthday): 20 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Marine Corps

10b KIND OF BUSINESS OR INDUSTRY: - - - -

11 BIRTHPLACE (State or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Daniel COLLINS

14 MOTHER'S MAIDEN NAME: Margaret STARR

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — If yes, give war or dates of service: 1956 to DOD

16 SOCIAL SECURITY NO: 180-30-8304

17 INFORMANT: (M) Mrs. Margaret S. Collins, same as #2 — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18): Passenger in jeep which hit rut and overturned

20c TIME OF INJURY: Hour 9:30 a.m. — Month Day: 2-20 — Year: 1959

20d INJURY OCCURRED: While at work ☒ — Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.): Street

20f (City or town) (County) (State): Marine Corps Base, Quantico, Va.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2-27-59

EXAMINER'S NAME (Type): Frank J. BROSCHART, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 3-2-59

22c NAME OF CEMETERY OR CREMATORY: Arlington National

22d LOCATION (City, town, or county) (State): Arlington Va.

23 FUNERAL DIRECTOR'S SIGNATURE: Ernest A. Adams — ADDRESS: Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. DC

24a RECORDED BY REGISTRAR — DATE: MAR 2 59

24b REGISTRAR'S SIGNATURE: T. E. Kleb

TO DEPUTY MEDICAL EXAMINER: This certificate should be entered within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for Vital Records Files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation or removal and in any event within 72 hours after death.

VS A SME SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2043

CERTIFICATE OF DEATH

02014

Reg. Dist. No. 215

1 PLACE OF DEATH
a. County: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 21 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 1826 New Hampshire Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Frederick; Middle: Douglass; Last: COLLINS

4 DATE OF DEATH: Month: February; Day: 27; Year: 19 59

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8-24-93

9 AGE (In years last birthday): 65 yrs

UNDER 1 YEAR IF UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Special Policeman

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt.

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: Jeremiah COLLINS

14. MOTHER'S MAIDEN NAME: Mary (Unknown)

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI

16 SOCIAL SECURITY NO: 577-20-8757

17 INFORMANT: (W) Mrs. Amanda H. Collins, Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY — IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

330x

DUE TO (b): Hypertensive disease

DUE TO (c):

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — (b): 15 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19 WAS A TOXIC PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m.

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 26, 1959, to February 27, 1959, that I last saw the deceased alive on February 27, 1959, and that death occurred at 1:15P M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-27-59

PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN — Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-3-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Rufus N. Horton Co., 1322 U STREET, NW, Wash, DC

24a. REC'D BY REGISTRAR: DATE MAR 3 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2044

Reg. Dist. No. 0201

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 14422 BROOKFIELD DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First MARGARET Middle B Last COLLINS
4. DATE OF DEATH: Month FEB Day 7th Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT 23, 1890
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ROBERT E. WEAVER
14. MOTHER'S MAIDEN NAME: THERESA HALLINAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHN COLLINS Address: 7805 GREENWOOD AVE. TAKOMA PK. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-3 hours
DUE TO (b) Hypertensive Cardiovascular Disease — 6 years
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4439

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Pulmonary Obesity
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 3, 1959 to Feb 7, 1959, that I last saw the deceased alive on Feb 3, 1959, and that death occurred at 9 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifton R. Gruver M.D. ADDRESS (Street, city or town, state): 4325 49th St. N.W. DATE SIGNED: 2/7/59

PHYSICIAN'S NAME (Type): CLIFTON R. GRUVER 4325 49th St. N.W. 2/7/59

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 2-10 1959
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
22d. LOCATION (City, town, or county) (State): SUITLAND MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hauber ADDRESS: 3531 Ga Ave NW
24a. REC'D BY REGISTRAR DATE: FEB 10 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2045

CERTIFICATE OF DEATH

02016

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8800 Ridge Road

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 8800 Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Otto — Middle: Connell — Last: Cott

4 DATE OF DEATH: Month: 2 — Day: 10 — Year: 19 59

5 SEX: male
6. COLOR OR RACE: white
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/26/1892
9 AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Government Employe
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: John Wm. Cott
14. MOTHER'S MAIDEN NAME: Mary Victoria Johnson

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT: Address: Nora W. Cott-8800 Ridge Rd. Bethesda, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSE BY IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO (b) cardiac vascular renal disease — 6 yrs.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Aug 19 35 to Feb. 10 19 59 that I last saw the deceased alive on Feb. 7 19 59 and that death occurred at 6:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: E. E. Quayle M.D. — ADDRESS (Street, city or town, state): 1822 Biltmore St N.W. Washington D.C. — DATE SIGNED

PHYSICIAN'S NAME (Type): E.E. Quayle, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/13/59
22c NAME OF CEMETERY OR CREMATORY: Fort Arlington Cemetery
22d LOCATION (City, town, or county) (State): Arlington, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company — ADDRESS: Washington, D.C.
24a RECORDED BY REGISTRAR: DATE: FEB 16 59
24b REGISTRAR'S SIGNATURE: S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2046 **CERTIFICATE OF DEATH** 02017

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY [illegible] MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY [illegible]

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible] c. LENGTH OF STAY IN 1b 1 DAY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible] HOSPITAL

d. STREET ADDRESS [illegible] MONROE ST.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH Month / Day 4 Year 19 [illegible]

5. SEX [illegible] 6. COLOR OR RACE [illegible] 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH [illegible]

9. AGE (In years last birthday) yrs 16. UNDER 1 YEAR Months Days 17. UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) [illegible] 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) [illegible] 12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME Thomas R Cross Jr. 14. MOTHER'S MAIDEN NAME Jean Bernard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N (If yes, give war or dates of service) 16. SOC. AL SECURITY NO. — 17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart failure

DUE TO (b) Congenital Heart Disease.

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 4, 1959 19____ to Feb 4, 1959 19____ that I last saw the deceased alive on Feb 4, 1959, 19____, and that death occurred at 4:P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE Frederic Gerard Burke M.D.

PHYSICIAN'S NAME (Type) FREDERIC GERARD BURKE - 3118 16th ST N.W. - D.C

22a. BURIAL, CREMATION, REMOVAL (Specify) [illegible] 22b. DATE THEREOF [illegible] 22c. NAME OF CEMETERY OR CREMATORY [illegible] 22d. LOCATION (City, town, or county) (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible] 24a. REC'D BY REGISTRAR DATE [illegible] 24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1989 **CERTIFICATE OF DEATH** Reg. Dist. No. 2011

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2 USUAL RESIDENCE (Where deceased lived. If in institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 2013 Parkway Drive,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First John, Middle Lawson, Last Crothers III

4 DATE OF DEATH: Month [illegible], Day [illegible], Year 1959

5 SEX: Male
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: [illegible]/59
9 AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? America

13 FATHER'S NAME: John Lawson Crothers Jr.
14 MOTHER'S MAIDEN NAME: Betty Irene Browne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT: father Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY
(a) ATELECTASIS, RESORPTION TYPE — INTERVAL BETWEEN ONSET AND DEATH: 24 H.
DUE TO
(b) HYALINE MEMBRANE DIS. — life
DUE TO
(c)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year; Hour a.m. p.m.
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f (City or town) (County) (State)

21 I certify that I attended the deceased from [illegible] 19[illegible] to [illegible] 19[illegible], that I last saw the deceased alive on [illegible] 19[illegible], and that death occurred at 1:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph J. McDonald M.D.
ADDRESS (Street, city or town, state): 7309 Riggs Rd., Hyattsville, Maryland
DATE SIGNED: 3/1/59
PHYSICIAN'S NAME (Type): Joseph J. McDonald, M. D. 7309 Riggs Road, Hyattsville, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-3-1959
22c NAME OF CEMETERY OR CREMATORY: Rosebank
22d LOCATION (City, town, or county) (State): Calvert County Md

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph H. Grant
ADDRESS: North East Md
24a RECORDED BY REGISTRAR: MAR 4 59
DATE
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,3 File 2039 3-15-59 et

2047

CERTIFICATE OF DEATH

Reg. Dist. No. 02019

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Gaithersburg

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Route #3

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Gaithersburg~~ Germantown Rural

d. STREET ADDRESS: Route 5 # 1, Box 203

e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3 NAME OF DECEASED (Type or print): First Veirs Middle William J. Last Dawson

4 DATE OF DEATH: Month February Day 26 Year 1959

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1890

9 AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months 7 Days 27 IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William P. Dawson

14 MOTHER'S MAIDEN NAME: Emma Veirs

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO. 577-10-9562

INFORMANT: Virginia M. Dawson-wife-same as 2d Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420.1

DUE TO (b) Arteriosclerotic cardiovascular disease / 3 years

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Ventricular fibrillation

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour a.m. p.m. Month Day Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f City or town (County) (State)

21 I certify that I attended the deceased from Nov 11 1958, to Feb 26 19 59 (that I last saw the deceased alive on Feb 25, 1959 and that death occurred at 8:00 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Stephen C. Cromwell MD — ADDRESS (Street, city or town, state): 6131 Montgomery Ave. Rockville Md — DATE SIGNED: 2/26/59

PHYSICIAN'S NAME (Type): Stephen C. Cromwell

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2/28/59

22c NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery

22d LOCATION (City, town, or county, State): Beallsville, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland

24a REC'D BY REGISTRAR: DATE MAR 2 '59

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the local director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or local burial, cremation, or removal and in any event within 72 hours after death.

VS A15 [4] 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2048

CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1 PLACE OF DEATH
a COUNTY: Montgomery Co. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney, Md.
c LENGTH OF STAY IN 1b: 15 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland
b COUNTY: Mont. Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md.
d STREET ADDRESS: 821 Snider Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Anderson Last: Deitz

4. DATE OF DEATH: Month: 2 Day: 8 Year: 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-28-89 69
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director retired
10b KIND OF BUSINESS OR INDUSTRY: Postal Transp. Personnel U. S. Gov't.
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Robert A. Deitz
14. MOTHER'S MAIDEN NAME: Mary Stull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Medical Records, Address: Olney, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Uremia
DUE TO (b) Acute recurrent
DUE TO (c)

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 14 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Injury vs. Vascular Disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-25, 19[illegible] to 2-8, 19[illegible], that I last saw the deceased alive on 2-8, 19[illegible], and that death occurred at 12:[illegible] P. M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE [illegible] M.D.

PHYSICIAN'S NAME (Type) C. H. Ligon, M.D. Sandy Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/11/59
22c. NAME OF CEMETERY OR CREMATORY: RIVERVIEW CEMETERY
22d. LOCATION (City, town, or county) (State): STRASBURG, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER F. MURPHEY, INC. ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE FEB 1 [illegible] 59
24b. REGISTRAR'S SIGNATURE: Arthur J. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2049

Reg Dist No 12021

1 PLACE OF DEATH
a COUNTY Montgomery
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 2 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LeDean Gardens Nursing Home

MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE Md
b COUNTY Monty
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1611 Moffett Rd
d STREET ADDRESS Silver Spring

INSIDE CORPORATE LIMITS YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First LILLIE Middle Loretta Last Dern

4 DATE OF DEATH Month Feb Day 22 Year 1959

5. SEX Female
6 COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH AUGUST 3 1877
9 AGE 81 yrs
IF UNDER 1 YEAR Months Days; UNDER 24 HRS Hours Min

10a OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) D.C.
12 CITIZEN OF WHAT COUNTRY U.S.A.

13 FATHER'S NAME Henry Barnstring
14 MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT Chas. F. Dern Address Silver Sp

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH sudden

DUE TO (b)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured hip about 3 mo. ago.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2-22-59

22a BURIAL CREMATION REMOVAL (Specify) Burial
22b DATE THEREOF Feb. 24, 1959
22c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d LOCATION (City, town, or county) (State) Prince George's County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc.
ADDRESS Silver Spring, Md.
24a REC'D BY REGISTRAR DATE
24b REG'STRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary please execute it by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be mailed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records. TO FUNERAL DIRECTOR. Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A SME
SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2050

Reg. Dist. No. 02022

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: RFD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mertie — Middle: Serena — Last: Ditzler
4. DATE OF DEATH: Month 2 Day 7 Year 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-14-75
9. AGE (In years last birthday): 83 yrs
F. UNDER 1 YEAR: Months 6 Days 13
F. UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James G. Wilson
14. MOTHER'S MAIDEN NAME: Susan Wallace
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Kyle H. Ditzler — Address: Rt 1 Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): [illegible]
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While of work ☐ Not while of work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1, 1959 to Feb. 7, 1959, that I last saw the deceased alive on Feb. 7, 1959, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen C. Cromwell M.D. — ADDRESS (Street, city or town, state): 415 W. Montgomery St. — DATE SIGNED: 2/8/59

PHYSICIAN'S NAME (Type): Stephen C. Cromwell — Rockville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 2/10/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county) (State): Whittier, California

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey-Bethesda, Md.
ADDRESS
24a. REC'D BY REGISTRAR: DATE FEB 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A 5 (4)
ISM 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2051 — 0202 — Reg Dist No

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write R.F.D. and nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 7 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2910 Blue Ridge Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write R.F.D. and give nearest town): Silver Spring
d. STREET ADDRESS: 2910 Blue Ridge Ave
e. S.R. O.A.P.A.R.: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Agnes Louise Dodson (First, Middle, Last)
4. DATE OF DEATH: Month Feb, Day 28, Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-19-1901
9. AGE (In years last birthday): 58 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Dept of Agri.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?: U S A
13. FATHER'S NAME: MICHAEL J. Weyrich
14. MOTHER'S MAIDEN NAME: Gertrude [redacted] STEWART
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Roy E Dodson — Address: [illegible]

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart, M.D.
EXAMINER'S NAME (Type): FRANK J Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-28-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/3/59
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WAYNE E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE MAR 4 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute here [illegible] the word "pending" in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1, 2 and 3 with the State Board of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2052

00751

Reg Dist No

1 PLACE OF DEATH
a COUNTY Montgomery
b CITY OR TOWN (If outside corporate limits, write RURAL) Bethesda
c LENGTH OF STAY IN 1b DOA
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital

MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE Maryland b COUNTY Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
d STREET ADDRESS 3415 Wake Drive
e DID DECEDENT ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Jeanine Middle Carole Last Duvall
4 DATE OF DEATH Month February Day 2 Year 1959
5 SEX Female
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH December 23, 1958
9 AGE (In years. Last birthday) — yrs (If under 1 year) Months 1 Days 10 (If under 24 hrs) Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----------
10b KIND OF BUSINESS OR INDUSTRY ----------
11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bernard Edward Duvall
14 MOTHER'S MAIDEN NAME Grace Beverly Simmonds
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO No
17 INFORMANT Bernard Duvall (Father) Address 3415 Wake Dr. Kensington, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Asphyxia
DUE TO
(b) Upper Respiratory Infection
DUE TO
(c)
475X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH
Found collapsed in bed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) State

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Bresnahan M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2-2-59
EXAMINER'S NAME Type FRANK J. BRESNAHAN

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 2/4/59
22c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
22d LOCATION (City, town, or county) (State) Baltimore, Md.
23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey, Bethesda, Maryland
24a REC'D BY REGISTRAR DATE FEB 5 59
24b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Funeral Director. Page 4 should be delivered to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation, or removal and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2053 **CERTIFICATE OF DEATH** Reg. Dist. No. 02024

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 2/14/59
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LE DEAU GARDENS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 732 THAYER AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle EDWARD Last FAULCONER
4. DATE OF DEATH: Month FEB. Day 23 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 8, 1877
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUSINESS REP., SHEET METAL WORKERS UNION
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CULPEPPER, VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN B. FAULCONER
14. MOTHER'S MAIDEN NAME: MARY UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 579-01-4807
17. INFORMANT: MRS. ROBERT J. LEARY, Address: 3830 WENDY LANE, SILVER SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adeno carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 11 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 23, 1956, to Feb 23, 1959, that I last saw the deceased alive on Feb 19, 1959, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Aaron H. Traum M.D. ADDRESS (Street, city or town, state): 8237 Georgia Ave Silver Spring Md DATE SIGNED: Feb 23 59.
PHYSICIAN'S NAME (Type): AARON H. TRAUM

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: FEB. 25, 1959
22c. NAME OF CEMETERY OR CREMATORY: GEORGE WASHINGTON CEMETERY RIGGS RD., PR. GEO. CO., MD.
22d. LOCATION (City, town, or county) (State):
23. FUNERAL DIRECTOR'S SIGNATURE: Raymond C. Zirna ADDRESS: WAGNER E. PUMPHREY, INC. SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE FEB 25 '59
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2054

CERTIFICATE OF DEATH

Reg Dist No 12025

1 PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN (b): 132 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14,
d. STREET ADDRESS: 6407 Winnepeg Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kathleen Middle: Marie Last: Finetti
4. DATE OF DEATH: Month: February Day: 8, Year: 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1952
9. AGE (in years last birthday): 6 yrs
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Finetti
14. MOTHER'S MAIDEN NAME: Marie Lanahan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gram Negative Septicaemia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Acute Lymphocytic Leukemia — months
DUE TO
(c)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month Day Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 29 1958 to February 8 1959, that I last saw the deceased alive on February 8, 1959 and that death occurred at 2:20a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Nathan S. Taylor MD — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 2/8/59

PHYSICIAN'S NAME (Type): NATHAN S. TAYLOR, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/11/59
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
22d. LOCATION (City, town, or county) (State): Montgomery Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: W. A. Humphreys and Son — ADDRESS: 5138 Ga Ave
24a. RECORDED BY REGISTRAR: DATE FEB 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2055 **CERTIFICATE OF DEATH** Reg. Dist. No. 1202

1 PLACE OF DEATH a. COUNTY: Montgomery ~~Prince George~~ MARYLAND

2 USUAL RESIDENCE (Where deceased ved if institution Residence before admission) a. STATE: Maryland b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lewisdale,

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lewisdale,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2010 Avalon Place,

d. STREET ADDRESS: 2010 Avalon Place

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marguerite Middle Mary Last Fitzpatrick

4. DATE OF DEATH: Month February Day 6, Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1898

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lawrence A. Kelly

14. MOTHER'S MAIDEN NAME: Margaret May

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -

16. SOCIAL SECURITY NO: ?

17. INFORMANT: James J. Fitzpatrick, Address: 2010 Avalon P l.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Coronary Artery Heart Disease — 2 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1952, to February 6, 59 that I last saw the deceased alive on February 6, 1959, and that death occurred at 4:00 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Robert B. Irey M.D. ADDRESS (Street, city or town, state): 7105 Riggs Road, Hyattsville, Md. DATE SIGNED: 2/6/59

PHYSICIAN'S NAME (Type): Robert B. Irey

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 10, 1959

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Dow Weed ADDRESS: 2224 Wis. Ave. N.W. - D.C.

24a. REC'D BY REGISTRAR DATE: FEB. 0 59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician or [illegible] TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1990 CERTIFICATE OF DEATH

Reg. Dist. No. 02027

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium Hosp

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: —
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 24 Cu 19th St. Apt 104
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Maria; Middle: Martha; Last: Fodor

4 DATE OF DEATH: Month: 2; Day: 10; Year: 1959

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 6-15-99
9 AGE (In years last birthday): 59 yrs
F. UNDER 1 YEAR: Months / Days
G. UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Emil Roob
14. MOTHER'S MAIDEN NAME: Maria Huszar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac - Respiratory failure
DUE TO (b): - Malnutrition and sec anemia
DUE TO (c): - Cancer of the bowel & metastasis to the liver

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): —
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 23 1958, to Feb. 10 1959, that I last saw the deceased alive on Feb. 9 1959, and that death occurred at 2:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Veronica Troost M.D. — ADDRESS (Street, city or town, state): 10236 N. Dixie, Silver Spring, Maryland — DATE SIGNED:
PHYSICIAN'S NAME (Type): VERONICA TROOST

22a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
22b. DATE THEREOF: [illegible]
22c. NAME OF CEMETERY OR CREMATORY: [illegible]
22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]
24a. RECEIVED BY REGISTRAR: DATE FEB 1 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2056 **CERTIFICATE OF DEATH** Reg. Dist. No. 112124

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 2 days & 5 hrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

d. STREET ADDRESS: 152 C Colony Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ANGELA Last FOY

4. DATE OF DEATH: Month Feb. Day 19 Year 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17, 1959

9. AGE (In years last birthday): 0 yrs. If under 1 year: Months 0 Days 2 If under 24 hrs.: Hours 5 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Bethesda, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William J. Foy

14. MOTHER'S MAIDEN NAME: Elizabeth Mess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William J. Foy, 152 C. Colony Rd., Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH 2 DAYS

116X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEB. 7, 1959, to FEB. 14, 1959, that I last saw the deceased alive on FEB. 14, 1959, and that death occurred at 4:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George R. Spence M.D. — ADDRESS (Street, city or town, state): 1515 HIGHLAND DRIVE SILVER SPRING MD. — DATE SIGNED

PHYSICIAN'S NAME (Type): GEORGE R. SPENCE M.D. SILVER SPRING, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/20/59

22c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

22d. LOCATION (City, town, or county) (State): Montgomery County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zicka — ADDRESS: Warner E. Pumphrey, Inc., Silver Spring, Md.

24a. RECEIVED BY REGISTRAR: DATE FEB 20 59

24b. REGISTRAR'S SIGNATURE

6/XVV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2057 CERTIFICATE OF DEATH

Reg. Dist. No. 12043

1. PLACE OF DEATH a. COUNTY: Montgomery Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4914-Freeway Drive
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: ✓

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Springs Md.
d. STREET ADDRESS: 4914-Freeway Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie Middle: Amy Last: Freet
4. DATE OF DEATH: Month: Feb. Day: 22 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 20, 1871
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Wesley Hess
14. MOTHER'S MAIDEN NAME: Elizabeth Robinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 578-26-4840A
17. INFORMANT: Mrs Ruth Greenfeld Address: 4914-Freeway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): MASSIVE GASTROINTESTINAL HEMORRHAGE (RUPTURED VARICES (ESOPHAGEAL))
DUE TO (b): HEPATIC COMA
DUE TO (c): CHRONIC LIVER DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): NONE
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.: NONE 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY, 1958, to FEBRUARY, 1959, that I last saw the deceased alive on FEBRUARY 21, 1959, and that death occurred at 1:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Witowski Jr. M.D. ADDRESS (Street, city or town, state): SUITE 400, 8218 WISCONSIN AVE. DATE SIGNED: 2/22/59

PHYSICIAN'S NAME (Type): EDWARD S. WITOWSKI JR M.D. BETHESDA 14 MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/25/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Adams Funeral Home ADDRESS: 4748-Wis ave Wash. DC
24a. REC'D BY REGISTRAR DATE FEB 2 7 9
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11,12 Film G238 2-1 et

1991 **CERTIFICATE OF DEATH** 2031

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. San + Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 641 Sligo Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Sherrie; Middle: Lynn; Last: Friedlander

4 DATE OF DEATH: Month: Feb.; Day: 6; Year: 59

5 SEX: F.
6 COLOR OR RACE: Wh
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct. 26-58
9 AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 3; Days: 11; IF UNDER 24 HRS.: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Mr. Jerome Friedlander
14 MOTHER'S MAIDEN NAME: DORIS OSHINSKY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: None.
17 INFORMANT: father — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGENITAL CARDIAC SEPTAL DEFECT — INTERVAL BETWEEN ONSET AND DEATH: SINCE BIRTH

DUE TO (b)

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (b) POSSIBLE CEREBRAL PALSY (c) POSSIBLE MICROCEPHALY

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from Feb. 3 1959 to Feb. 6 1959, that I last saw the deceased alive on Feb. 5 1959, and that death occurred at 8:20 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Stanley Gould M.D.
ADDRESS (Street, city or town, state): 3222 Davenport St. N.W. Washington, D.C.
DATE SIGNED: 2/6/59
PHYSICIAN'S NAME (Type): STANLEY GOULD.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 6, 1959
22c NAME OF CEMETERY OR CREMATORY: Bnai Israel Cem.
22d LOCATION (City, town, or county) (State): Oxon Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE: B. Danzansky + Sons
ADDRESS: 5315-3101-14th St. N.W.
24a REC'D BY REGISTRAR: DATE Feb. 3
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be carried with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
ISM 9-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2058 **CERTIFICATE OF DEATH** Reg. Dist. No. 02031

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN b: 2½ Years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mrs. Pauline Boyd's Nursing 1800 Grace Church Road

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. STREET ADDRESS: 1908 Hanover Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First PAUL Middle S. Last GABLE

4 DATE OF DEATH: Month Feb Day 7 Year 1959

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 8-14-70

9 AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Referee

10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt. Printg. Of.

11 BIRTHPLACE (State or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Jacob Benton Gable

14 MOTHER'S MAIDEN NAME: Caroline A. Staley

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: None

17 INFORMANT: Paul DeLong Gable, Address: 1908 Hanover St, S.S. Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: Few hours

DUE TO (b) Cardio Vascular Renal Disease — 10 yrs.

DUE TO (c) Arteriosclerosis — 10 yrs.

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Feb. 1, 1959 to Feb. 7, 1959, that I last saw the deceased alive on Feb. 6, 1959, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lynwood Heiges M.D. ADDRESS (Street, city or town, state): 6401 Piney Branch Rd. DATE SIGNED: 2/7/59

PHYSICIAN'S NAME (Type): LYNWOOD HEIGES, M.D. FACA

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: Feb. 10, 1959

22c NAME OF CEMETERY OR CREMATORY: MacPelah Cemetery

22d LOCATION (City, town, or county) (State): Lititz, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Wagner E. Humphrey, Inc. ADDRESS: Silver Spring, Md. Raymond A. Zloka

24a. REC'D BY REGISTRAR DATE: FEB 10 59

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2059

CERTIFICATE OF DEATH

Reg. Dist No. 2032

PLACE OF DEATH a. COUNTY [illegible] MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]

c. LENGTH OF STAY IN 1b [illegible]

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE [illegible] b. COUNTY [illegible]

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]

d. STREET ADDRESS [illegible]

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH Month [illegible] Day [illegible] Year 19[illegible]

5. SEX [illegible]

6. COLOR OR RACE [illegible]

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH [illegible]

9. AGE (In years last birthday) [illegible] yrs.

IF UNDER 1 YEAR: Months [illegible] Days [illegible] IF UNDER 24 HRS: Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]

10b. KIND OF BUSINESS OR INDUSTRY [illegible]

11. BIRTHPLACE (State or foreign country) [illegible]

12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME [illegible]

14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]

16. SOCIAL SECURITY NO. [illegible]

17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

460X

DUE TO Cause Undetermined

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Arteriosclerosis disease of heart — 1 year

DUE TO

(c) Diabetes Mellitus — 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour [illegible] a.m. p.m. 19[illegible]

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [illegible]

20f. (City or town) [illegible] (County) [illegible] (State) [illegible]

21. I certify that I attended the deceased from [illegible], 19[illegible] to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) [illegible] DATE SIGNED [illegible]

ACTUAL SIGNATURE [illegible] M.D.

PHYSICIAN'S NAME (Type) [illegible]

22a. BURIAL, CREMATION, REMOVAL—(Specify) [illegible]

22b. DATE THEREOF [illegible]

22c. NAME OF CEMETERY OR CREMATORY [illegible]

22d. LOCATION (City, town, or county) [illegible] (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible]

24a. RECEIVED BY REGISTRAR DATE FEB 10 59

24b. REGISTRAR'S SIGNATURE Arthur S. Keane

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
35M 10/57

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M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2060

Reg. Dist. No. 02033

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 5926 - 13th Place N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ellen (NELL) Middle L Last Glynn
4. DATE OF DEATH: Month Feb Day 4 Year 19 59
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/21/87
9. AGE (In years last birthday): 71 yrs
UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Huron County Ohio
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Arthur J. Cahill
14. MOTHER'S MAIDEN NAME: ELLEN [redacted] CONNERS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MARGARET GLYNN - (Above) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONset AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Sigmoid Colon — 3 yrs
1523
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Coronary Thrombosis, Fracture Rt hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-15-57, 19__, to _____, 19__, that I last saw the deceased alive on 2-2-59, 19__, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew J. Betz MD — ADDRESS (Street, city or town, state): 5412 Lake Ave. N.W. Wash. D.C. — DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 2-5-59
22c. NAME OF CEMETERY OR CREMATORY: Calvary Cem
22d. LOCATION (City, town, or county) (State): Toledo Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Georgia N.W.
24a. RECD BY REGISTRAR: DATE FEB 9 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2061

Reg. Dist. No. 02034

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAIRLAND NURSING HOME

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: DISTRICT COLUMBIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 4
d. STREET ADDRESS: 2216 - 8th St N W
e. 5 RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DINAH Middle ~~[illegible]~~ Last GORDAN
4. DATE OF DEATH: Month Feb. Day 27 Year 1959
5. SEX: F
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY: of Russia

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INTERMENT: Ralph Gordon Son Address: Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b) Cancer of rectum — 6 mons.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1947, to Feb. 27, 1959, that I last saw the deceased alive on Feb. 26, 1959, and that death occurred at 1:55 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Simon C Weiner MD M.D.
ADDRESS (Street, city or town, state): 100 Longfellow St N.W.
DATE SIGNED: 3-1-59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 3/1/59
22c. NAME OF CEMETERY OR CREMATORY: GOLDSTEINS FUNERAL HOME
22d. LOCATION (City, town, or county) (State): WHEATON MD

22. FUNERAL DIRECTOR'S SIGNATURE: Goldsby Funeral Home
ADDRESS: 4217 - 9th St NE
24a. REC'D BY REGISTRAR DATE MAR 2 59
24b. REGISTRAR'S SIGNATURE: Carlton S. Manuel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be securely attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2062 CERTIFICATE OF DEATH

Reg. Dist. No. 2035

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 mo 3 wks
d. NAME OF HOSPITAL (If dead in hospital, give street address) OR INSTITUTION: Brooke Grove Chronic Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Washington
d. STREET ADDRESS: 408 Kennedy St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry Middle G. Last Gossage
4. DATE OF DEATH: Month Feb. Day 14 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 9 1882
9. AGE (If years lost birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter Int. Decorator
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harry Gossage
14. MOTHER'S MAIDEN NAME: Mary Frances Straum
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 579-48-8172
17. INFORMANT: Mrs. Emma Gossage (wife) 408 Kennedy St N.W. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO (b) cerebral vascular accident — 3 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic duodenal ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 23 1958 to Feb. 14 1959 that I last saw the deceased alive on Feb 5 1959, and that death occurred at 10:20 A.M. from the causes and on the date stated above

ACTUAL PHYSICIAN'S NAME (Type): John R. Spencer M.D. — ADDRESS (Street, city or town, state): Columbia Road Burtonsville, Md. — DATE SIGNED

JOHN R. SPENCER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-17-59
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Lon. McCall — ADDRESS: Wash. D.C. 2224 Wis. Ave. N.W.
24a. REC'D BY REGISTRAR: DATE FEB
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached for use as the burial transit permit. Pages 1 and 2 should be delivered with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2063 CERTIFICATE OF DEATH

Reg. Dist. No. 02036

1 PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: [illegible] Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE [illegible]
b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: [illegible] Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jesse Middle: P. Last: [illegible]stein
4. DATE OF DEATH: Month: February Day: 12 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 20, 1902
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Doctor
10b. KIND OF BUSINESS OR INDUSTRY: [illegible]
11. BIRTHPLACE (State or foreign country): New York, N.Y.
12. CITIZEN OF WHAT COUNTRY? [illegible]
13. FATHER'S NAME: Louis Greenstein
14. MOTHER'S MAIDEN NAME: Lena Bernstein
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife Address: Mrs. Lucy [illegible] Greenstein [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Massive Acute Intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
440X
DUE TO
(b): Hypertensive Cardiovascular Disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George Sharpe M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 2/12/59
PHYSICIAN'S NAME (Type): George Sharpe Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 13, 1959
22c. NAME OF CEMETERY OR CREMATORY: King David Memorial Garden
22d. LOCATION (City, town, or county): Falls Church (State): Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible]
24a. REC'D BY REGISTRAR: DATE FEB 10 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No 02037

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN HOSPITAL: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Monty Co Gen. Hosp

2. USUAL RESIDENCE (Where decedent lived. If institution, ten days before admission)
a. STATE: Md
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt Airy (rural)
d. STREET ADDRESS: RFD #3
INSIDE CITY LIMITS? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest; Middle: Wilson; Last: Grimes

4. DATE OF DEATH: Month: 2; Day: 21; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-4-98

9. AGE (Years last birthday): 60 yrs

If UNDER 1 YEAR: Months ___ Days ___ If UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Labor

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Tom Grimes

14. MOTHER'S MAIDEN NAME: Anna Jane Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — If yes, give war or dates of service:

16. SOCIAL SECURITY NO: 579055354

17. INFORMANT: Mary Grimes (wife) — Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS A TOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-21-59

EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL: Burial

22b. DATE THEREOF: Feb. 24, 59

22c. NAME OF CEMETERY OR CREMATORY: Bethesda

22d. LOCATION (City, town, or county): Brookeville (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Maggie Kirkbride

ADDRESS: Laytonsville, Md

24a. REC'D BY REGISTRAR: DATE FEB 27 '59

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt exists as necessary please erase the rest and write the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Health Officer.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15ME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2065 **CERTIFICATE OF DEATH** Reg. Dist. No. 2038

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Potomac~~ Bethesda

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Ropine Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: District of Columbia b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

d. STREET ADDRESS: 4600 49th Street, N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRED Middle PRESTON Last GUTHRIE

4 DATE OF DEATH: Month Feb Day 6 Year 1959

5. SEX: male

6. COLOR OR RACE: white

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 29, 1891

9 AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio Communications

10b. KIND OF BUSINESS OR INDUSTRY: Radio Corp. of America

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Craig Guthrie

14. MOTHER'S MAIDEN NAME: Sallie Lyle Gilkeson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: —

17 INFORMANT: LeRoy Guthrie Address: 4600 49th St. N. W., Washington D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.

DUE TO (b) Subacute Bacterial Endocarditis — 9 mos.

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1, 1959 to 2-6, 1959. That I last saw the deceased alive on 2-2, 1959, and that death occurred at 7:15 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Hill Carter M.D. ADDRESS (Street, city or town, state): 1835 Eye St N.W. DATE SIGNED:

PHYSICIAN'S NAME (Type): HILL CARTER Washington DC

22a BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: Feb 7, 1959.

22c. NAME OF CEMETERY OR CREMATORY: Tinkleing Springs Pres. Church

22d. LOCATION (City, town, or county) (State): Fishersville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: C. F. Lee ADDRESS: 2847 Wilson Blvd. Arlington, Va.

24a REC'D BY REGISTRAR: Feb 9 59

24b. REGISTRAR'S SIGNATURE: L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2066 **CERTIFICATE OF DEATH**

Reg. Dist. No. 12039

PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Rockville, xMx

c. LENGTH OF STAY IN b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Residence

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville

d. STREET ADDRESS: Edison Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print) First: CAROLYN Middle: ANN Last: HALL

4. **DATE OF DEATH** Month: February Day: 27, Year: 1959

5. SEX: Female 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: Feb. 5, 1954

9. AGE (In years if under 1 year, if under 24 hrs. give last birthday): 5 yrs. Months: 0 Days: 22 Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William G. Hall

14. MOTHER'S MAIDEN NAME: Anna Hartman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: -----

INFORMANT: Wm. G. Hall-Item # 2 Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute lymphatic leukemia — Interval between onset and death: 3 wks.

204.3

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town County State

21. I certify that I attended the deceased from Feb. 2 1959 to Feb. 27 1959 that I last saw the deceased alive on Feb. 27 1959 and that death occurred at 2 p. m. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL SIGNATURE: Stephen C. Crane, M.D. Leisa, Montgomery Co. Md.

PHYSICIAN'S NAME (Type): Stephen C. Crane, M.D. Rockville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/2/59

22c. NAME OF CEMETERY OR CREMATORY: Parklawn

22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey-Bethesda, Md. ADDRESS

24a. REC'D BY REGISTRAR DATE MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove coroner's page. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 4-75 (4) 15M 9-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2067 **CERTIFICATE OF DEATH** Reg. Dist. No. 12040

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5704 Huntington Pkw.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Fredric — Middle: Albert — Last: HAMLIN

4 DATE OF DEATH: Month: Feb — Day: 7 — Year: 1959

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: May 3-905

9 AGE (In years last birthday): 53 yrs 6 — IF UNDER 1 YEAR: Months: — Days: 24 — IF UNDER 24 HRS: Hours: — Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): management

10b KIND OF BUSINESS OR INDUSTRY: Publishing

11 BIRTHPLACE (State or foreign country): Missouri

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Roy Hamlin

14 MOTHER'S MAIDEN NAME: Clarke

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16 SOCIAL SECURITY NO.: Unknown

17 INFORMANT: Margaret Hamlin — Address: 5704 Huntington Pkw.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 20 min
DUE TO
(b) Leukemia, myelogenous — 11 months
DUE TO
(c)

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from March 1956 to Feb 1959, that I last saw the deceased alive on Feb 7 1959, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert Martyn Jr. MD — ADDRESS (Street, city or town, state): 5029 Bethesda Ave — DATE SIGNED:

PHYSICIAN'S NAME (Type): HERBERT MARTYN JR — Bethesda, Md — 7 Feb 59

22a BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b DATE THEREOF: 2/11/59

22c NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d LOCATION (City, town, or county) (State): Hannibal, Missouri

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a REC'D BY REGISTRAR — DATE: FEB 11 '59

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2068 **CERTIFICATE OF DEATH** 02041

Reg. Dist. No

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Belmont Farm Convalescent Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Washington, D.C. b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47

d. STREET ADDRESS: 1701 Park Road, N.W.

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Emma Middle: Hammelstein Last:

4. DATE OF DEATH: Month: 2 Day: 5 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March 3, 1880

9. AGE (In years last birthday): 78 yrs.

If UNDER 1 YEAR: Months | Days | If UNDER 24 HRS: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Moses Mathis

14. MOTHER'S MAIDEN NAME: Rebecca Bukofzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Gerhard Hammerstein Address: 10038 Renfrew Rd., S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b): Cerebral Hemorrhage — years

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1/58 to 2/5/59, that I last saw the deceased alive on 2/3/59, and that death occurred at 6:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. W. Bird M.D.

ADDRESS (Street, city or town, state): Sandy Spring

DATE SIGNED: 2/5/59

PHYSICIAN'S NAME (Type): J. W. Bird, M.D. Sandy Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 6, 1959

22c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Cemetery

22d. LOCATION (City, town, or county) (State): Hyattsville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Danzansky & Sons ADDRESS: 3501 14th St., N.W.

24a. REC'D BY REGISTRAR DATE: FEB 3 9

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2069 **CERTIFICATE OF DEATH** Reg. Dist. No. 0242

1 PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 137 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 3205 Winnett Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Virginia Middle: M. Last: HARDING
4 DATE OF DEATH: Month: Feb. Day: 20 Year: 1959
5 SEX: Female 6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9/5/14
9 AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11 BIRTHPLACE (State or foreign country): Chicago, Ill.
12 CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Ray Hammond
14 MOTHER'S MAIDEN NAME: ~~Unknown~~ Catherine Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: Dean H. Harding, M.D. (same as #2) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal Obstruction — 72 hrs.
DUE TO (b) Paralytic Intestinal Ileus — 2 days
DUE TO (c) Carcinoma Colon — 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from [illegible] 19[illegible] to [illegible] 19[illegible], that I last saw the deceased alive on [illegible] 19[illegible], and that death occurred at [illegible] M., from the causes and on the date stated above

ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED
PHYSICIAN'S NAME (Type) [illegible]

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 23 1959
22c. NAME OF CEMETERY OR CREMATORY: Parkview Cemetery
22d. LOCATION (City, town, or county) (State): Montgomery County, Md.
23 FUNERAL DIRECTOR'S SIGNATURE: J. Arthur [illegible] ADDRESS: 254 Carroll St. N.W. D.C.
24a. RECORDED BY REGISTRAR: FEB 2 [illegible]
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible]erat director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1992 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12043

Reg Dist No.

PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) [illegible]

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
d. STREET ADDRESS [illegible]
INSIDE CITY LIMITS? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: [illegible] Middle: L. Last: HARRISON
4. DATE OF DEATH Month: FEB Day: 3 Year: 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: SEPT. 28, 1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]
10b. KIND OF BUSINESS OR INDUSTRY: [illegible]
11. BIRTHPLACE (State or foreign country): [illegible]
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): [illegible]
16. SOC. SECURITY NO.
17. INFORMANT: [illegible] Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary occlusion

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Found dead on living room floor

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Had been dead several days when found.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, off. or bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural cause ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-6-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/6/59
22c. NAME OF CEMETERY OR CREMATORY: [illegible]
22d. LOCATION (City, town, or county, State): [illegible]
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: [illegible]
24a. REC'D BY REGISTRAR: DATE FEB 9 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate marking the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be returned to the State Board of Health.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A 5ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2070 **CERTIFICATE OF DEATH** 2044

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN HOSPITAL: 34 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): The District of Columbia
d. STREET ADDRESS: 1016 49th Street, N. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Alice — Middle: Luticia — Last: Hawkins

4 DATE OF DEATH: Month: February — Day: 17, — Year: 1959

5 SEX: Female

6 COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: November 14, 1908

9 AGE (In years last birthday): 50 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Charwoman

10b KIND OF BUSINESS OR INDUSTRY: Government

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY: U. S. A.

13 FATHER'S NAME: Thurman Watkins

14 MOTHER'S MAIDEN NAME: Lucinda Watkins

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: Unavailable

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSE BY IMMEDIATE CAUSE (a): Pulmonary Embolism
460 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a): Tuberculous Meningitis

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from January 14, 1959, to February 17, 1959, that I last saw the deceased alive on February 17, 1959, and that death occurred at 5:00 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Albert Treger M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 2-18-59

PHYSICIAN'S NAME (Type): Albert Treger, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2/21/59

22c NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

22d LOCATION (City, town, or county): Washington — (State): D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: Lee F. Palmer — ADDRESS: 412 H St, N.E. Washington D.C.

24a RECD BY REGISTRAR: DATE FEB 19 '59

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be cleared by the hospital or attending physician. Page 1 and 2 should be filed in by the funeral director

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02045

2071 **CERTIFICATE OF DEATH**

Reg Dist. No.

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 129 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 447 University Boulevard, East

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Milton Middle: Francis Last: Heffernan

4 DATE OF DEATH: Month: February Day: 16, Year: 1959

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: October 24, 1917

9 AGE (In years last birthday): 41 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if not ret'd): Budget Examiner

10b. KIND OF BUSINESS OR INDUSTRY: Government

11 BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Harry Heffernan

14 MOTHER'S MAIDEN NAME: Mary Flaherty

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: 577-09-4586

17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest followed by Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b) Increased Intracranial Pressure — Months

DUE TO (c) Adenocarcinoma, Primary Undetermined, with Metastasis to Cerebellum and Lung, — Years

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I attended the deceased from October 10, 1958 to February 16, 1959 that I last saw the deceased alive on February 16, 1959, and that death occurred at 8:29 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: G. Milton Shy M.D.

ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland

DATE SIGNED: 2-17-59

PHYSICIAN'S NAME (Type): G. Milton Shy, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/20/59

22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY

22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.

24a. RECEIVED BY REGISTRAR DATE: FEB 19 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) ISM 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1993 CERTIFICATE OF DEATH

Reg. Dist. No. 12046

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
c. LENGTH OF STAY IN 1b: 1 mon. 12 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Washington Sanitarium & Hospital
e. STREET ADDRESS: 7106 45th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase 15,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John Middle Everett Last Hendricks
4. DATE OF DEATH: Month Feb. Day 2 Year 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-15-93
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Patent Examiner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ky.
12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: Albert E. Hendricks
14. MOTHER'S MAIDEN NAME: Laura Allender
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service): WWI Army
16. SOCIAL SECURITY NO.:
17. INFORMANT: Pt's Chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: (a) Generalized Carcinomatosis
DUE TO: (b) Corkscrewing Perforating Perforating Ulcer
DUE TO: (c) Arteriosclerosis
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 2 Mos
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Nephrosclerosis Hypertrophy — Left Renal Atrophy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month Day Year Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-6 19 58 to 2-2 19 57 that I last saw the deceased alive on 1-2-19 59 and that death occurred at 9:15 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Leonard C. Broughton M.D.
ADDRESS (Street, city or town, state): 934 Edward Rittenhouse Jr. Rd.
DATE SIGNED:
PHYSICIAN'S NAME (Type): M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2-6-59
22c. NAME OF CEMETERY OR CREMATORY: Rees Crematory
22d. LOCATION (City, town, or county) (State): 3004 1st St. N.E. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Lee
ADDRESS: 3004 1st St. N.E.
24a. RECD BY REGISTRAR: DATE FEB 9 '59
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL ■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1994 Birth Certificate

CERTIFICATE OF DEATH

04530

Reg. Dist. No

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Ho

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland
b COUNTY: Prince Georges
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
d STREET ADDRESS: Box 265 Springfield Road,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Hobbs

4 DATE OF DEATH: Month: February — Day: 23, — Year: 19 59

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 2/23/59 @ 8:15 am
9 AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 12 — Min 5

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? America

13 FATHER'S NAME: Edward Dorsey Hobbs
14. MOTHER'S MAIDEN NAME: Patricia Louise Cauffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: father — Address: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Prematurity + atelectasis
DUE TO
(b)
DUE TO
(c)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: –

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from 2/23, 19 59 to ..., 19..., that I last saw the deceased alive on 2/23/59, 19 59, and that death occurred at 8:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. G. Preisser M.D.
ADDRESS (Street, city or town, state): 8418 New Hampshire Ave., Silver Spring, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): W. G. Preisser, M. D. — 8418 New Hampshire Ave., Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b DATE THEREOF: 2-25-59
22c NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hosp.
22d. LOCATION (City, town, or county) (State): Takoma Park, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Hare, M. D. Washington Sanitarium and Hosp., Takoma Park, Maryland
24a. RECEIVED BY REGISTRAR: APR 24 59
DATE
24b REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 4

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2022

2047

Reg Dist No

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 16 - DC
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5404 Blackstone Rd

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Washington 16 - DC
d. STREET ADDRESS: 5404 Blackstone Rd
OUTSIDE CITY LIMITS? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julian — Middle: Lawrence — Last: Holley
4. DATE OF DEATH: Month: Feb — Day: 22 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-25-'98
9. AGE (In years last birthday): 60 yrs
UNDER 1 YEAR: Months, Days, Hours, Min.
UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Applied Physics Lab
11. BIRTHPLACE (State or foreign country): Conn
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Julian R. Holley
14. MOTHER'S MAIDEN NAME: Calista Brockett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Helen Holly (wife) — Address: Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous coronary occlusion
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS: PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-22-59

22a. BURIAL, CREMATION OR REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/26/1959
22c. NAME OF CEMETERY OR CREMATORY: Newton Crematorium
22d. LOCATION (City, town or county) (State): Newton, Mass
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawlers Sons
ADDRESS: 1756 Pa. Ave N.W. D.C.
24a. REC'D BY REGISTRAR DATE: FEB 24
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be returned for [illegible]

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AFSME 5M 2 57

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02045

Reg Dist No

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c LENGTH OF STAY IN (b): 49 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7200 Holly Ave.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland
b COUNTY: Montg.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d STREET ADDRESS: 7200 Holly Ave.
e INSIDE CORPORATE LIMITS: YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John, Middle, Last Humphrey Sr.
4 DATE OF DEATH: Month Feb., Day 4, Year 1959
5. SEX: male
6 COLOR OR RACE: white
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 10/12/1877
9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): salesman
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): D.C.
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Humphrey
14. MOTHER'S MAIDEN NAME: Connor
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)
16 SOCIAL SECURITY NO
17 INFORMANT: Adelia H. Frazier — Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous heart desease
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) State

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐, Homicide ☐ undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart
M.D. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/5/59
EXAMINER'S NAME (Type): Frank J. Broschart

22a BURIAL CREMATION REMOVAL (Specify): Burial
22b DATE THEREOF: Feb. 7, 1959
22c NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d LOCATION (City, town, or county) (State): Washington, D.C.
23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: [illegible] 254 [illegible]
24a RECORDED BY REGISTRAR DATE: FEB 9 '59
24b REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2073 **CERTIFICATE OF DEATH**

Reg. Dist No 215

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c LENGTH OF STAY IN 1b: 12 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland
b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d STREET ADDRESS: 1606 Brisbane Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Robert; Middle: Lincoln; Last: HUMPHREYS

4 DATE OF DEATH: Month: February; Day: 4; Year: 1959

5 SEX: Male
6 COLOR OR RACE: Caucasian
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 8-27-20
9 AGE (In years last birthday): 38 yrs
UNDER 1 YEAR: Months | Days | Hours | Min
UNDER 24 HRS

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio Engineer
10b KIND OF BUSINESS OR INDUSTRY: Federal Aviation Ag.
11 BIRTHPLACE (State or foreign country): Washington, D. C.
12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: Lincoln HUMPHREYS
14 MOTHER'S MAIDEN NAME: Julia YOUNGQUIST

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown): Yes — (If yes, give war or dates of service): WW II
16 SOCIAL SECURITY NO:
17 INFORMANT: (W) Mrs. Mary Louise Humphreys, same as #2 above — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Malignant melanoma with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO: (Primary site: left scapula region)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year; Hour a.m. p.m.
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from January 23, 1959, to February 4, 1959, that I last saw the deceased alive on February 4, 1959, and that death occurred at 10:45AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-4-59

PHYSICIAN'S NAME (Type): R. C. THOMAS, LT, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-9-59
22c NAME OF CEMETERY OR CREMATORY: Arlington National
22d LOCATION (City, town, or county) (State): Arlington, Va.

23 FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: R.A. Purtphrey Funeral Home, Bethesda, Md.
24a REC'D BY REGISTRAR: DATE FEB 0 9
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2074 **CERTIFICATE OF DEATH** Reg. Dist. No. 121 (51)

1 PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

c. LENGTH OF STAY IN 1b: 7 months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MARILEA NURSING HOME

d. STREET ADDRESS: 508 MISSISSIPPI AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: ANNA Middle: ROBERTA Last: HUNTER

4 DATE OF DEATH: Month: FEB. Day: 27 Year: 1959

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug. 5, 1873

9 AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b KIND OF BUSINESS OR INDUSTRY: Stationary Store

11 BIRTHPLACE (State or foreign country): Washington, D. C.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: ROBERT H. HUNTER

14 MOTHER'S MAIDEN NAME: MARY FRANCES NOLLAN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16 SOCIAL SECURITY NO.: NONE

17 INFORMANT: Mrs. Virginia E. Rowe, Address: 508 Mississippi Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): [illegible]

DUE TO (b): [illegible]

DUE TO (c): [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from [illegible], 1955, to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 2 27 59

PHYSICIAN'S NAME (Type): JOHN S. ROGERS

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 3/2/59

22c NAME OF CEMETERY OR CREMATORY: OAK HILL CEMETERY

22d LOCATION (City, town, or county, State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR: DATE MAR 2 '59

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2075

CERTIFICATE OF DEATH

Reg. Dist. No. 02051

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1819 North Fairfax Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: Elizabeth — Last: Husbands

4 DATE OF DEATH: Month: February — Day: 12, — Year: 1959

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: August 2, 1889
9 AGE (In years last birthday): 69 yrs
If UNDER 1 YEAR: Months: Days: If UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): Delaware
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Benjamin Chiffins
14 MOTHER'S MAIDEN NAME: Emily Ellen James

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.: None
17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myelogenous leukemia — INTERVAL BETWEEN ONSET AND DEATH: Months

DUE TO

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute hemorrhagic pneumonia — Days

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 1. Bronchiectasis 2. Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Hour: a. m. p. m. Month: Day: Year: 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from January 28, 1959, to February 12, 1959, that I last saw the deceased alive on February 12, 1959, and that death occurred at 4:05 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur T. Teplitzky M.D.
ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2-13-59
PHYSICIAN'S NAME (Type): Arthur T. Teplitzky, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify):
22b. DATE THEREOF:
22c NAME OF CEMETERY OR CREMATORY:
22d LOCATION (City, town, or county) (State):

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]
24a RECORD BY REGISTRAR: DATE: FEB 16 59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician on [illegible]. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00752

2076

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN THIS PLACE: 1 week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9208 Adelaide Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Rose — Last: Judice

4. DATE OF DEATH: Month: 2 — Day: 1 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 24 1898
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months: 11 — Days: 7 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dominic Izzo
14. MOTHER'S MAIDEN NAME: Filomena Yelardo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Son Carmen Joseph Judice — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b): Primary site unknown
DUE TO (c):

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 6, 1958 to Feb 1, 1959 that I last saw the deceased alive on Feb 1, 1959, and that death occurred at 8:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Allen J. O'Neill M.D. — ADDRESS (Street, city or town, state): 5604 Old Georgetown Rd — DATE SIGNED:

PHYSICIAN'S NAME (Type): Allen J. O'Neill — Bethesda 14 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/4/59
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
22d. LOCATION (City, town, or county) (State): Silver Spring, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 4 59
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2077 **CERTIFICATE OF DEATH** 02052

Reg. Dist No 215

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 27 days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4344 Texas Ave., S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

3. NAME OF DECEASED (Type or print): First: Henry — Middle: — Last: IRVING
4. DATE OF DEATH: Month: February — Day: 23 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-9-94
9. AGE (In years last birthday): 64 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO: 705-01-0801
17. INFORMANT: (W) Mrs. Florence Irving, same as #2 above — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Lobar pneumonia — 4 days
DUE TO (b) Coronary Arteriosclerosis — 1.2 yrs
DUE TO (c)
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 27, 1959, to February 23, 1959, that I last saw the deceased alive on February 23, 1959, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital — DATE SIGNED: 2-24-59

PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN — Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-1-59
22c. NAME OF CEMETERY OR CREMATORY: New Mount Baptist Church
22d. LOCATION (City, town, or county) (State): Arrington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: John T. Rhines & Co. — ADDRESS: 3015 - 12th NE.
John T. Rhines & Co., 901 3rd St., SW Wash., DC
24a. REC'D BY REGISTRAR: DATE FEB 26 59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2078 **CERTIFICATE OF DEATH** Reg. Dist. No. 12053

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY: Amherst

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN (b): 3 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Amherst

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: General Delivery

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Reuben Middle: Pettice Last: Iseman

4 DATE OF DEATH: Month: February Day: 26, Year: 19 59

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: January 21, 1914

9 AGE (In years last birthday): 45 yrs

IF UNDER 1 YEAR OR UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Link Iseman

14. MOTHER'S MAIDEN NAME: Alice Staples

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 225-28-8421

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar and Lobular Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

199.2

DUE TO (b) Malignant Carcinoid with widespread Metastases — Years

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 23, 19 59, to February 26, 19 59, that I last saw the deceased alive on February 26, 19 59, and that death occurred at 5:30 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: Eugene B. Feigelson M.D. ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED: 2-26-59

PHYSICIAN'S NAME (Type): Eugene B. Feigelson, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/ /59

22c. NAME OF CEMETERY OR CREMATORY: Amherst Cemetery

22d. LOCATION (City, town, or county) (State): Amherst, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. Demaine & Son Funeral Home, Alexandria, Va. ADDRESS

24a. REC'D BY REGISTRAR: DATE MAR 2 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death Page 4 may be returned to the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2079

CERTIFICATE OF DEATH

Reg. Dist. No. 02054

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN (b): 47 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY: Roanoke

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Roanoke

d. STREET ADDRESS: 2321 Garden City Boulevard, SE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Katherine Middle: Odell Last: Jamison

4 DATE OF DEATH: Month: February Day: 7, Year: 19 59

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: December 9, 1914

9 AGE (In years last birthday): 44 yrs

If UNDER 1 YEAR: Months Days

If UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Daniel Starkey

14 MOTHER'S MAIDEN NAME: Laua Guthrie

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16 SOCIAL SECURITY NO.: Undscertainable

17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Breast Metastases — 10 months

DUE TO (b)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from December 22, 1958 to February 7, 1959, that I last saw the deceased alive on February 7, 1959, and that death occurred at 9:55 a.m. from the causes and on the date stated above

ACTUAL SIGNATURE: Jack Levin M.D.

ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland

DATE SIGNED: 2-7-59

PHYSICIAN'S NAME (Type): Jack Levin, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: [illegible]

22c NAME OF CEMETERY OR CREMATORY: [illegible]

22d. LOCATION (City, town, or county) (State): Roanoke

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] Funeral Home ADDRESS: 305 West Ave Alexandria Virginia Va

24a REC'D BY REGISTRAR DATE: FEB 16 '59

24b REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 et

CERTIFICATE OF DEATH

2080

0205

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Washington
d. STREET ADDRESS: 708 4th Street, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Albert — Middle: Leon — Last: JONES

4 DATE OF DEATH: Month: February — Day: 5 — Year: 1959

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 7-7-~~80~~ 1890

9 AGE (In years last birthday): 68 ~~79~~ yrs. — IF UNDER 1 YEAR OR UNDER 24 HRS.: Months | Days | Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Guard

10b KIND OF BUSINESS OR INDUSTRY: U.S.Government

11 BIRTHPLACE (State or foreign country): Washington, D. C.

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: Unknown

14 MOTHER'S MAIDEN NAME: Sahrah TUTT

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI

16 SOCIAL SECURITY NO.: 577-16-0730

17 INFORMANT: (W) Mrs. Gladys Jones, same as #2 above — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year, Hour a. m. p. m.

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from February 3, 1959, to February 5, 1959 that I last saw the deceased alive on February 4, 1959, and that death occurred at 12:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE _____ M.D. ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-5-59

PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2-9-59

22c NAME OF CEMETERY OR CREMATORY: Arlington National

22d LOCATION (City, town, or county): Arlington — (State): Va.

23 FUNERAL DIRECTOR'S SIGNATURE: W. E. Jarvis Funeral Home — ADDRESS: 1432 U St. NW, Washington, DC

24a REC'D BY REGISTRAR: DATE FEB 9

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate can be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2081

CERTIFICATE OF DEATH

Reg. Dist. No. 0205

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Unity (Rural)
c. LENGTH OF STAY IN (b): 10 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Unity (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: — Last: Jones
4. DATE OF DEATH: Month: February — Day: 8 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 12, 1865
9. AGE (In years last birthday): 93 yrs.
If UNDER 1 YEAR: Months — Days — If UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. J.
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13. FATHER'S NAME: Cornelius Jones
14. MOTHER'S MAIDEN NAME: Mary Cassell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Laura Howard — Address: Brookeville, Md. R. F. D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Hemmiplegia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Arteriosclerotic Cardiorenal Disease
DUE TO
(c)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Inguinal Hernia.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month — Day — Year — Hour — a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 7, 55, to Feb. 8, 59, that I last saw the deceased alive on Feb. 7, 1959, and that death occurred at 3 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:
PHYSICIAN'S NAME (Type): Webster Sewell, M.D. — Rt. 1 Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/10/59
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Park.
22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Rockville, Md.
24a. RECEIVED BY REGISTRAR: DATE FEB 13 59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2082 **CERTIFICATE OF DEATH** Reg. Dist. No. 12057

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN (b): 42 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: West Virginia b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheeling

d. STREET ADDRESS: 214 Warwood Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theodore Middle: Allen Last: Kavrakis

4. DATE OF DEATH: Month: February Day: 15, Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 15, 1956

9. AGE (In years last birthday): 2 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Theodore Kavrakis

14. MOTHER'S MAIDEN NAME: Shirley Harwatt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastroenteritis hemorrhagic

200.2 DUE TO (b) malignant hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 4, 1959, to February 15, 1959, that I last saw the deceased alive on February 15, 1959, and that death occurred at 9:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE _____ M.D. ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland DATE SIGNED: 2-15-59

PHYSICIAN'S NAME (Type): James M. Marsh, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur Transit

22b. DATE THEREOF: 2/16/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

22d. LOCATION (City, town, or county) (State): Wheeling, W Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 1 1959

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 141
15M 9 55

1 D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2083 **CERTIFICATE OF DEATH** Reg. Dist. No. 2058

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N. Chevy Chase
d. STREET ADDRESS: 3210 Woodhollow Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Evelyn Last Kay
4. DATE OF DEATH: Month February Day 11 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 13, 1898
9. AGE (In years last birthday): 61 yrs
UNDER 1 YEAR: Months 0 Days 28
IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
11. BIRTHPLACE (State or foreign country): Louisiana, U.S.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Cullem W. Kay
14. MOTHER'S MAIDEN NAME: Emily N. Wright
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Wm. P. Weber-346 Luhman, Milford, N. J. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction of the [illegible] hemisphere
DUE TO
(b) Arteriosclerosis
DUE TO
(c)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1957 to Jan. 1959, that I last saw the deceased alive on Feb. 11, 1959, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. ADDRESS (Street, city or town, state): 4890 Battery Lane, Bethesda DATE SIGNED: 2/11/59

PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut 4890 Battery Lane, Beth. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/13/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. RECEIVED BY REGISTRAR DATE FEB 1[illegible]
24b. REGISTRAR'S SIGNATURE

Coroner Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2084 **CERTIFICATE OF DEATH** Reg. Dist. No. 1120 [illegible]

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN (b): 2 yrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Rose Crane Foundation

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Village

d. STREET ADDRESS: 7213 Maryland Terrace

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Christopher Middle: Joseph Last: Keller

4 DATE OF DEATH: Month: Feb Day: 19 Year: 19[illegible]

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-25-1873

9. AGE (In years last birthday): 85 yrs

UNDER 1 YEAR: Months Days

UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N.Y. City

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jos. Keller

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hastiné [illegible] Son Address:

MED. CAL. CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute versus influenza + Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

DUE TO (b): Acute Suppurative Pharyngitis — [illegible] 2 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Ca of Pharynx + Lymphadenitis, Metast — 4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Injured Pharynx from X-Ray — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month Day Year Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 hours, 19[illegible] to 2-14, 19[illegible], that I last saw the deceased alive on 14 Feb, 1954, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Bosley Boyer M.D. — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED: [illegible]

PHYSICIAN'S NAME (Type): JOHN B. BOYER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-21-1954

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Silver Spring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James A. Mattingly — ADDRESS: 131 [illegible]

24a. REC'D BY REGISTRAR: DATE FEB 24

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02061

2085 CERTIFICATE OF DEATH

Reg. Dist No. 215

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda (Rural)
c LENGTH OF STAY IN 1b: 80 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: District of Columbia — b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 4, D.C.
d STREET ADDRESS: 1293 Brentwood Rd, N.E. - Apt 2D
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Fred — Middle: Colburn — Last: KELLY
4 DATE OF DEATH: Month: February — Day: 18 — Year: 1959
5 SEX: Male
6. COLOR OR RACE: Caucasian
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4-23-95
9 AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. OCCUPATION (Give kind of work done during most of working life even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Contractor
11 BIRTHPLACE (State or foreign country): Michigan
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: Charles KELLY
14 MOTHER'S MAIDEN NAME: Julia Bell LEE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI
16 SOCIAL SECURITY NO: 578-32-6528
17 INFORMANT: (W) Patrice Kelly, same as 2 above — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH
141.9
DUE TO (b) Primary carcinoma, lungs — 6 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from November 30, 1958, to February 18, 1959, that I last saw the deceased alive on February 18, 1959, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Troy M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-19-59
PHYSICIAN'S NAME (Type): J. W. TROY, CDR, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: 2-24-59
22c NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county): Arlington — (State): Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: Leroy E. Chambers — ADDRESS: Same
L.W. Chambers, 1400 Chapin St., NW, Wash, D.C.
24a REC'D BY REGISTRAR — DATE
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2086

Reg. Dist. No. 02061

1 PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 4102 Oliver Street

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4102 Oliver Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle J. Last KENEALY
4. DATE OF DEATH: Month 2 Day 11 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-3-16
9. AGE (In years last birthday): 42 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FISCAL ANNALIST
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gov't.
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN T. KENEALY
14. MOTHER'S MAIDEN NAME: CATHERINE S. COLLINS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War 2
16. SOCIAL SECURITY NO.: 578 46 268
17. INFORMANT: MARY ALICE KENEALY Address: Same as "D"

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 M.
DUE TO (b): Bronchogenic carcinoma — 13 M.
DUE TO (c):
162.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NAE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAR. 1, 19 58, to FEB. 11, 19 59, that I last saw the deceased alive on FEB. 11, 19 59, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Tuohy M.D. ADDRESS (Street, city or town, state): 7720 WISCONSIN AVE. DATE SIGNED: 2/11/59

PHYSICIAN'S NAME (Type): JOHN H. TUOHY, M.D. 7720 Wisconsin Ave. Bethesda, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-14-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Kelly ADDRESS: Wash. D. C.
FRANCIS J. COLLINS 3821 14th. St.N.W.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2087

CERTIFICATE OF DEATH

02062

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 629 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sta[illegible] Care [illegible] Lane Bethesda

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 5616 Wilson Lane.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARLOTA Middle DA COSTA Last KENNEDY
4. DATE OF DEATH: Month FEB. Day 12 Year 1959
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 4, 1869
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Carlos Mexia
14. MOTHER'S MAIDEN NAME: Julia Foster
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Joyce [illegible] Address: 5616 Wilson Lane Bth

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROSIS, GENERAL — INTERVAL BETWEEN ONSET AND DEATH: YEARS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 1955 to FEB. 12, 1959, that I last saw the deceased alive on FEB. 12, 1959, and that death occurred at 9:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo M. Curtis M.D. — ADDRESS (Street, city or town, state): 8218 Wisconsin Ave., Bethesda Md. — DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): Leo M Curtis — 8218 Wisconsin Ave, Bethesda Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/14/59
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] & Hines Co — ADDRESS: [illegible] W. [illegible] D.C.
24a. REC'D BY REGISTRAR: FEB 16 59 — DATE
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician or TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 35M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2088 — Reg. Dist. No. 2063

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betnesda
c. LENGTH OF STAY IN: 37½ Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2305 Churchill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: R. — Last: Ketay

4. DATE OF DEATH: Month: Feb. — Day: 26 — Year: 19 59

5. SEX: White
6. COLOR OR RACE: Female
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 9/9/90
9. AGE (In years last birthday): 68 yrs.
If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Milton Sand
14. MOTHER'S MAIDEN NAME: Marian (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: 577-32-6884A
17. INFORMANT: Son Mr. Toby Jaffe — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
(a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 hours
332X
DUE TO
(b) Cerebral arteriosclerosis — unknown
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Abdominal aortic - cause unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 6, 1958 to February 26, 1959, that I last saw the deceased alive on February 26, 1959, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Aaron H. Traum M.D. — ADDRESS (Street, city or town, state): 8237 Georgia Ave. Silver Spring, Md. — DATE SIGNED: Feb 26 '59

PHYSICIAN'S NAME (Type):

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/27-1959
22c. NAME OF CEMETERY OR CREMATORY: National Capital Mem Cem
22d. LOCATION (City, town, or county) (State): Washington DC

23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home — ADDRESS: 4217 Georgia Ave NW DC
24a. RECEIVED BY REGISTRAR — DATE: MAR 2 [illegible]
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the coroner director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2089 **CERTIFICATE OF DEATH** Reg. Dist. No. 02064

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cedar Grove
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: RFD # 1 Germantown

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cedar Grove
d. STREET ADDRESS: RFD # 1 Germantown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Jessie Middle: Matilda Last: King
4 DATE OF DEATH: Month: Feb. Day: 7 Year: 1959
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct. 16, 1896
9 AGE (In years at last birthday): 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own home
11 BIRTHPLACE (State or foreign country): Brooklyn, N.Y.
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: William King
14 MOTHER'S MAIDEN NAME: Lillian Burke
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT: Address: Mr. Lee M. King, RFD 1, Germantown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE) (a) Coronary occlusion — 3 hours
420.1
DUE TO (b) Arteriosclerotic cardiovascular disease — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Feb. 10, 1945 to Feb. 7, 1959, that I last saw the deceased alive on Feb. 7, 1959, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D. ADDRESS (Street, city or town, state): Damascus Md. DATE SIGNED: 2/9/59

PHYSICIAN'S NAME (Type): James P. Kerr Damascus, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Feb. 10, 1959
22c NAME OF CEMETERY OR CREMATORY: Salem Methodist
22d. LOCATION (City, town, or county) (State): Cedar Grove, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth ADDRESS: Damascus, Md.
24a. RECORDED BY REGISTRAR DATE: FEB 11 '59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2090

02065

Reg Dist No

1 PLACE OF DEATH
a COUNTY Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville
c LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md R-109

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE Md b COUNTY Monty
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus
d. STREET ADDRESS
e. DO REVENUE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Thomas Middle: Russell Last: Kinna ~~Kinder~~
4 DATE OF DEATH Month: Feb Day: 8 Year: 1959
5 SEX Male
6 COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 4-4-33
9 AGE In years ~~Last birthday~~ 25 yrs
If UNDER 1 YEAR Months Days
If UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b KIND OF BUSINESS OR INDUSTRY Auto parts
11 BIRTHPLACE (State or foreign country) md
12 CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Russell ~~Kinder~~ Kinna
14 MOTHER'S MAIDEN NAME Wady Morningstar
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or peacetime period) CO - US Navy
16 SOCIAL SECURITY NO 214-36-3574
17 INFORMANT Russell Kinna Address Comus Md

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO (b) Fracture of skull
DUE TO (c) Multiple injuries, extreme
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS A TOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Passenger on drunk in car which left highway
20c TIME OF INJURY Hour 3 a.m. p.m. Month, Day 2-8 Year 1959
20d INJURY OCCURRED White of work ☐ Not white of work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f (City or town) Barnesville (County) Monty (State) Md

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart
EXAMINER'S NAME (Type) FRANK J. Broschart
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2-8-59

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/11/59
22c. NAME OF CEMETERY OR CREMATORY Monocacy
22d LOCATION (City, town or county) Buckeystown State Md

23 FUNERAL DIRECTOR'S SIGNATURE Wallace B. Hilton
ADDRESS Barnesville Md
24a REC'D BY REGISTRAR DATE FEB 11 59
24b REGISTRAR'S SIGNATURE [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [illegible]
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

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5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2091 **CERTIFICATE OF DEATH** Reg. Dist. No. 02066

1 PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL, INC.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission.) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X DERWOOD
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First MYRTLE Middle JANE Last KISNER
4 DATE OF DEATH: Month FEBRUARY Day 26 Year 1959
5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 6/3/44
9 AGE (In years last birthday): 14 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: ROBERT BOWIE KISNER
14 MOTHER'S MAIDEN NAME: ROSE REBECCA EMORY
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: HOSPITAL RECORDS Address: OLNEY, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

2040

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month Day Year Hour a. m. p. m.
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from ..... 19 .. to Feb 26 1959, that I last saw the deceased alive on Feb 24 1959, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard C. Yates M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type): R. A. YATES, M. D. OLNEY, MARYLAND

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-28-59
22c NAME OF CEMETERY OR CREMATORY: Bethel Church Cemetery
22d. LOCATION (City, town, or county): Germantown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner, Gaithersburg, Md.
ADDRESS
24a. RECD BY REGISTRAR, DATE: MAR 2 '59
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00753

2092

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rockville
c. LENGTH OF STAY IN (b): 2½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: River Road, Rt. 2, Rockville

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rockville
d. STREET ADDRESS: River Road, Rt. 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First Philip — Middle Marion — Last Knox

4 DATE OF DEATH: Month February — Day 1 — Year 1959

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: December 16, 1879

9 AGE (In years last birthday): 79 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HR.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant--Treas.

10b. KIND OF BUSINESS OR INDUSTRY: Govt. Employee

11 BIRTHPLACE (State or foreign country): Alexandria, Virginia

12 CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Robert F. Knox

14. MOTHER'S MAIDEN NAME: Lucy Smith

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: [illegible]

17 INFORMANT: Mrs. John C. Adams, Rt. 2., Rockville, Md. — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Leukemia and Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 9 Months

1172

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Cardio-vascular Disease

19 WAS A AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from May 19 58, to 1 Feb 19 59, that I last saw the deceased alive on 30 January 1959, and that death occurred at 5:30 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE: W. F. Cresswell, Jr. M.D. — ADDRESS (Street, city or town, state): 2029 Que St. N.W., Wash., D.C. — DATE SIGNED: 2-1-59

PHYSICIAN'S NAME (Type): W. F. Cresswell, Jr.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2-3-59

22c NAME OF CEMETERY OR CREMATORY: Sharon

22d LOCATION (City, town, or county) (State): Middleburg Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: Morris Roupter — ADDRESS: Middleburg, Va.

24a. RECEIVED BY REGISTRAR: DATE FEB 3 '59

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place remaining carbon papers, Pages 1 and 2 should be detached with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

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Item 18 Film 239 2-25-59 ams

2093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN (b): 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: C
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park
d. STREET ADDRESS: 11 Balanaua Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lynda — Middle: Jean — Last: KOLBAS
4. DATE OF DEATH: Month: February — Day: 15 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-9-59
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months — Days: 6 — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Leon R. KOLBAS
14. MOTHER'S MAIDEN NAME: Mary N. O'HARE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bacteremia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
053.3
DUE TO (b): Pseudomonas aeruginosa
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month — Day — Year — Hour — a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 13, 1959, to February 15, 1959, that I last saw the deceased alive on February 15, 1959, and that death occurred at 7:30P M from the causes and on the date stated above.

ACTUAL SIGNATURE: David Harris M.D — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-16-59

PHYSICIAN'S NAME (Type): David HARRIS, LT, MC, USN — Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-20-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: E. H. Adams — ADDRESS: Adams Funeral Home, 4748 Wisc.Ave.NW, Wash.,DC
24a. RECEIVED BY REGISTRAR: DATE FEB 1 5 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2094 **CERTIFICATE OF DEATH** Reg. Dist. No. 02068

1 PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION ALTA VISTA NURSING HOME

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BETHESDA
d. STREET ADDRESS 6504 MILLWOOD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Nurse Betty Koonce
4. DATE OF DEATH Month Feb Day 26 Year 1959
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1/8/1886
9. AGE (Last birthday) 73 yrs
If UNDER 1 YEAR Months Days Hours; If UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Harltown, West Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Koonce
14. MOTHER'S MAIDEN NAME Hattie Mohler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Mrs. Leslie Erhardt Address same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Infarct
DUE TO (b) Acute Cholecystitis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Emphysema, Cardiac Hypertrophy, Arteriosclerosis, CASHD, Arrhythmia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town (County) (State)

21. I certify that I attended the deceased from 1941 to Feb 26, 1959 that I last saw the deceased alive on Feb 22 1959 and that death occurred at 6:24 PM from the causes and on the date stated above.
ACTUAL SIGNATURE Thos F Kelleher M.D. ADDRESS (Street, city or town, state) 1150 Conn Ave Washington DC DATE SIGNED 2/26/59
PHYSICIAN'S NAME (Type) Thomas F. Kelleher 1150 Conn. Ave. N.W.

22a. BURIAL, CREMATION, REMOVAL (Specify) burial
22b. DATE THEREOF 3/2/59
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery
22d. LOCATION (City, town, or county) (State) Harpers Ferry, West Va.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE MAR 2 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2095 **CERTIFICATE OF DEATH** Reg Dist No. 0206

PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

c. LENGTH OF STAY IN this place: 1 month

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitarium

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

d. STREET ADDRESS: 11205 Waycross Way

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIAS Middle I. Last KOZAK

4. DATE OF DEATH: Month February Day 24 Year 1959

5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 28, 1897 9. AGE (in years) (last birthday): 61 yrs IF UNDER 1 YEAR: Months 6 Days 26 IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (State or foreign country): Ukraine

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Kozak

14. MOTHER'S MAIDEN NAME: Pauline Saj

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): Yes Not US

16. SOCIAL SECURITY NO: 113-05-8830

INFORMANT: Anne Van Meter-niece Address: Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma Lung, Lower. — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

1 DUE TO (b) Hypernephroma left Kidney. — 1 year

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month Day Year Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town County State

21. I certify that I attended the deceased from January, 1959 to February 24, 1959 that I last saw the deceased alive on January 21 1959 and that death occurred at 1:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Blaine Fitzgerald M.D. ADDRESS (Street, city or town, state): 8218 Wisconsin Ave Bethesda DATE SIGNED: 2/24/59

PHYSICIAN'S NAME (Type): J. Blaine Fitzgerald 8218 Wisc. Ave. Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit 22b. DATE THEREOF: 2/27/59

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey Bethesda, Maryland

24a. RECORDED BY REGISTRAR DATE MAR 2 59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A 5 4, 15M 9 58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1996 **CERTIFICATE OF DEATH** 00754

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN (b): 8 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7100 Sycamore Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,

d. STREET ADDRESS: 7100 Sycamore Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: N. Last: KROUT

4. DATE OF DEATH: Month: Feb. Day: 3 Year: 1959

5. SEX: Female 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 10, 1864

9. AGE (In years last birthday): 94 yrs IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Lehigh County, Pa.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William Snyder

14. MOTHER'S MAIDEN NAME: Angelina ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Russell S. Krout, 6817 5th St., N.W. D.C. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

DUE TO (b): Myocardial Infarction — 48 hrs

DUE TO (c): Coronary Arteriosclerosis — 20 yrs

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 2, 1959, to Feb. 3, 1959, that I last saw the deceased alive on Feb. 3, 1959, and that death occurred at 4:30 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Charles T. Carroll M.D. (Coroner Approved signing) ADDRESS (Street, city or town, state) DATE SIGNED 2/3/59

PHYSICIAN'S NAME (Type): Charles T. Carroll 6801 6th St. N.W. Washington, D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: Feb. 6. 1959 22c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery 22d. LOCATION (City, town, or county) (State): Silver City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 254 Carroll St. N.W. D.C.

24a. REC'D BY REGISTRAR DATE: FEB 6 59

24b. REGISTRAR'S SIGNATURE: [illegible]

HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the coroner, TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02070

2096

Reg Dist No

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 112 Northbrook Lane

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda

d. STREET ADDRESS: 112 Northbrook Lane

OF A FARM YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: LULA Middle: MIDDLETON Last: LANDES

4 DATE OF DEATH Month: February Day: 13, Year: 19 59

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Aug. 1, 1870 (1872)

9 AGE (If under 1 year, give months and days) 86/88 yrs. IF UNDER 1 YEAR: Months 6 Days 12 IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: Own Home

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U S

13 FATHER'S NAME: John Middleton

14 MOTHER'S MAIDEN NAME: Sarah McDonald

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: None

17 INFORMANT: Mrs. Helen Ellison Address: 5522 Greentree Rd Bethesda, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO (b): Coronary arteriosclerosis — 5 yrs.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and my opinion on death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

2/13/59

22a BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b DATE THEREOF: 2/16/59

22c NAME OF CEMETERY OR CREMATORY: Thorne Rose

22d LOCATION (City, town, or county) (State): Staunton, Va.

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-Bethesda, Maryland

24a REC'D BY REGISTRAR DATE: FEB 1 9

24b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be written within 24 hours after death. If any delay is necessary please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be retained by the Medical Examiner. Page 5 may be returned for [illegible] Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or as designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A SME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2097 **CERTIFICATE OF DEATH** Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 4343 Montgomery Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Lewis Last: Langlois
4. DATE OF DEATH: Month: 2 Day: 13 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 24 1892
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months: 2 Days: 19 IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Steamship Co.
11. BIRTHPLACE (State or foreign country): Vermont
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Louis Langlois
14. MOTHER'S MAIDEN NAME: Rose Tiard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 279-18-9741 [redacted]
17. INFORMANT: Wife. Address: Mabel Langlois - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia of the lt lung
177 X
DUE TO (b): Excision of the prostate gland c metastasis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month Day Year Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 1, 1958 to Feb. 13, 1959, that I last saw the deceased alive on Feb 13, 1959, and that death occurred at 6:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Washington Clinic, Wash. D. C. DATE SIGNED: 2/13/59

PHYSICIAN'S NAME (Type): Arthur P. Hessler Washington Clinic, Wash. D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/16/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. RECD BY REGISTRAR DATE: FEB 16 9
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2098 **CERTIFICATE OF DEATH**

Reg Dist No 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 54 days
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Ohio
b. COUNTY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cleveland Heights
d. STREET ADDRESS: 1943 Revere Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Arthur — Middle: Saul — Last: LANSKY

4 DATE OF DEATH: Month: February — Day: 19 — Year: 1959

5 SEX: Male — 6 COLOR OR RACE: Caucasian — 7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 1-21-36

9 AGE (In years last birthday): 23 yrs — IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Marine Corps

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Ohio

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis LANSKY

14 MOTHER'S MAIDEN NAME: Nettie FIERMAN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1956 to DOD

16 SOCIAL SECURITY NO: 280-30-6605

17 INFORMANT: (F) Louis Lansky, same as #2 above — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH

1747

DUE TO (b): Choriocarcinoma origin unknown 8 months

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month — Day — Year — Hour a. m. p. m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) — 20f (City or town) (County) (State)

21 I certify that I attended the deceased from December 27 1958 to February 19 1959, that I last saw the deceased alive on February 19 1959, and that death occurred at 4:25A M from the causes and on the date stated above

ACTUAL SIGNATURE: Jack D. Real M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital — DATE SIGNED: 2-19-59

PHYSICIAN'S NAME (Type): Jack D. REAL, LT, MC, USN — Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment 2-19-59

22b DATE THEREOF

22c NAME OF CEMETERY OR CREMATORY: Mount Olive

22d LOCATION (City, town, or county) (State): Cleveland Ohio

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. DC

24a. RECORD BY REGISTRAR — DATE FEB 2 1

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02167

2099

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 12321 Dewey Rd

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12321 Dewey Rd
e. IS REFERENCE CASE? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Layshon — Last: Lemaster
4. DATE OF DEATH: Month: Feb — Day: 9 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-22-1929
9. AGE (In years, last birthday): 29 yrs
10. UNDER 1 YEAR: Months: | Days: | HOURS: | MIN:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Webster H. Layshon
14. MOTHER'S MAIDEN NAME: Hilda Chadwick
~~Richard Lemaster~~ — ~~Stem 2~~
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Richard Lemaster — Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): hanging
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 974X
INTERVAL BETWEEN ONSET AND DEATH: sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): hung self by neck in basement of her home
20c. TIME OF INJURY: Month, Day, Year; Hour: a.m. p.m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒, Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart, M.D.
NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-9-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/12/59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [redacted]. Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

VS A15ME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2100

Reg. Dist. No. 02014

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: NORWOOD ROAD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: EMANUEL; Middle: --; Last: LOMAX
4. DATE OF DEATH: Month: FEBRUARY; Day: 7; Year: 1959
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3/7/75
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM WORKER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: WILLIAM NATHANIEL LOMAX
14. MOTHER'S MAIDEN NAME: LOUISE WILLIAMS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HOSPITAL RECORDS — Address: OLNEY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) [illegible]
DUE TO (b) [illegible]
DUE TO (c)

441X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month; Day; Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/2 1959 to 2/7 1959, that I last saw the deceased alive on 2/7 1959, and that death occurred at 11:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonfeant M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type): A. D. BONFEANT, M. D. — SANDY SPRING, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/10/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant.
22d. LOCATION (City, town, or county) (State): Norbeck, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Rockville, Md.
24a. RECEIVED BY REGISTRAR: DATE FEB 10 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2101

Reg. Dist. No. 02075

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: - - - - -
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7306 Delfield Street

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 7306 Delfield Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First AIMEE, Middle EUGENIE, Last LYFORD

4 DATE OF DEATH: Month Feb., Day 3, Year 19 59

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct. 8, 1875
9 AGE (in years last birthday): 83 yrs
IF UNDER 1 YEAR: Months 3, Days 25, Hours, Min
IF UNDER 24 HRS

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher-Ret.
10b. KIND OF BUSINESS OR INDUSTRY: School Teacher
11 BIRTHPLACE (State or foreign country): Rock Island, Ill.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert E. Lyford
14 MOTHER'S MAIDEN NAME: Clara Burgh

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - - -
16 SOCIAL SECURITY NO.: None
INFORMANT: Harry B. Lyford - as above #2 Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3 wks X Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b) Arteriosclerotic Cerebral Vascular Disease — 5 years

DUE TO (c)

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from April 1954 to Feb. 3 1959 that I last saw the deceased alive on Feb. 3 1959 and that death occurred at 3:30 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Charles E. Woodson M.D.
ADDRESS (Street, city or town, state): 1801 Eye St N.W. - Wash 6, D.C.
DATE SIGNED:

PHYSICIAN'S NAME (Type): Charles E. Woodson, 1801 Eye St., N. W., Washington 6, D. C.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-7-59
22c NAME OF CEMETERY OR CREMATORY: Chippiannock Cem.
22d LOCATION (City, town, or county) (State): Rock Island, Illinois

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda 14, Md.
ADDRESS:
24a. REC'D BY REGISTRAR: DATE FEB 6 '59
24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS ATS (4) SM 9 58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2102 **CERTIFICATE OF DEATH**

Reg. Dist No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 34 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased ved if institution Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 407 18th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick; Middle:; Last: MARESCH
4. DATE OF DEATH: Month: February; Day: 17; Year: 1959
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-29-03
9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): State Department
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Govt.
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Frederick MARESCH
14. MOTHER'S MAIDEN NAME: Louise VALENTINE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY — IMMEDIATE CAUSE (a) Infarction, myocardium — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

241 and

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last:
(b) Pericarditis — 5 days
Secondary to
(c) Leukemia, myelogenous, acute — 10 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 14, 1959, to February 17, 1959, that I last saw the deceased alive on February 17, 1959, and that death occurred at 9:50A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J T Horgan M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-17-59

PHYSICIAN'S NAME (Type): J. T. HORGAN LCDR MC USN — Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-21-59
22c. NAME OF CEMETERY OR CREMATORY: Fairmount Cemetery
22d. LOCATION (City, town or county) (State): Newark, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Humphrey — ADDRESS: R.A. Humphrey Funeral Home, Bethesda, Md.
24a. RECD BY REGISTRAR: DATE FEB 19 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please empty carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) RSM 10-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1

2103

CERTIFICATE OF DEATH

Reg. Dist. No. 2178

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At home - 5001 Danbury Court

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 5001 DANBURY COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First VICTOR — Middle FRANK — Last MARIANI
4. DATE OF DEATH: Month FEB — Day 19 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 8, 1903
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUILDER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): RAPPINO, ITALY
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: FRANK MARIANI
14. MOTHER'S MAIDEN NAME: MARIA SIMEONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: THEODORE F. MARIANI — Address: 5001 DANBURY CT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Peripheral Shock — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Gastro intestinal Hemorrhage — 2 days
DUE TO
(c): Primary Carcinoma of liver — 8 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1958, to February, 1959, that I last saw the deceased alive on Feb 19, 1959, and that death occurred at 5:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph R. Patten M.D. — ADDRESS (Street, city or town, state): 8641 Colesville Road — DATE SIGNED: Feb 19, 59
PHYSICIAN'S NAME (Type): RALPH F. PATTEN M.D. — Silver Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2-23-59
22c. NAME OF CEMETERY OR CREMATORY: NAT. MEM. PARK
22d. LOCATION (City, town, or county) (State): FALLS CHURCH - VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon — ADDRESS: 9831 GA. AVENUE
24a. REC'D BY REGISTRAR — DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1997 CERTIFICATE OF DEATH

Reg. Dist. No. 12079

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12018 Georgia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roland Middle: Miskel Last: Marks
4. DATE OF DEATH: Month 2 Day 7 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-19-1900
9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Butcher
10b. KIND OF BUSINESS OR INDUSTRY: Safeway Stores
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel D Marks
14. MOTHER'S MAIDEN NAME: Myrtle Marks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: wife - Mrs Beatrice R Marks - James. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Acute Myocardial Infarction — 5/2-6 hrs

DUE TO (c) Arteriosclerotic heart disease — and terminal

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month Day Year Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/7, 1959, to 2/7, 1959, that I last saw the deceased alive on 2/7, 1959, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Marvin L. Kolkin M.D. ADDRESS (Street, city or town, state): 8485 Fenton Street, S.S., Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Marvin L. Kolkin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 10, 1959
22c. NAME OF CEMETERY OR CREMATORY: Welcome Grove Baptist Church Cemetery
22d. LOCATION (City, town, or county) (State): Warsaw, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Sleka ADDRESS: Warner E. Pumphrey, Inc., Silver Spring, Md.
24a. RECEIVED BY REGISTRAR DATE: FEB 10 59
24b. REGISTRAR'S SIGNATURE: Cathy J. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A16 (4) 15M 9 '55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1998 CERTIFICATE OF DEATH

Reg. Dist. No. 12181

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN (b): 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: —
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wash. D.C.
d. STREET ADDRESS: 431 Randolph St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allen — Middle: Johnson — Last: Marsh

4. DATE OF DEATH: Month: Feb. — Day: 15 — Year: 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-12-62
9. AGE (In years last birthday): 96 yrs.
If UNDER 1 YEAR: Months — Days — If UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired): Retired-Teacher
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Mahlon Marsh
14. MOTHER'S MAIDEN NAME: Lida Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): —
DUE TO
(b) Uremia & terminal coma — 24 hours
DUE TO
(c) Chronic glomerulo nephritis — 3 years

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month — Day — Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/20 19 57 to 2/14 19 58, that I last saw the deceased alive on 2/14 19 58, and that death occurred at 6:15 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: Hugh W. Irey, M.D. — ADDRESS (Street, city or town, state): 7105 Baltimore Rd. Hyattsville, Md. — DATE SIGNED: 2/16/58

PHYSICIAN'S NAME (Type): Hugh W. Irey

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2/18/59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Ft. Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: 2901 14th St.
24a. RECEIVED BY REGISTRAR: DATE FEB 17 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2104

CERTIFICATE OF DEATH

Reg. Dist. No. 02051

1 PLACE OF DEATH a. COUNTY [illegible] MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING

c. LENGTH OF STAY IN 1b [illegible]

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8530 Second Avenue

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE [illegible] b. COUNTY [illegible]

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]

d. STREET ADDRESS [illegible]

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: [illegible] Last: [illegible]

4. DATE OF DEATH Month: [illegible] Day: 13 Year: 1959

5. SEX [illegible] 6. COLOR OR RACE [illegible] 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH [illegible] 9. AGE (In years last birthday) [illegible] yrs. IF UNDER 1 YEAR: Months / Days / Hours / Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Depot Clerk

10b. KIND OF BUSINESS OR INDUSTRY [illegible]

11. BIRTHPLACE (State or foreign country) [illegible]

12. CITIZEN OF WHAT COUNTRY [illegible]

13. FATHER'S NAME [illegible]

14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]

16. SOCIAL SECURITY NO. YES

17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) [illegible]

DUE TO (b) [illegible]

DUE TO (c) [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] AM, from the causes and on the date stated above.

ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED [illegible]

PHYSICIAN'S NAME (Type) PHILIP E. JONES

22a. BURIAL, CREMATION, REMOVAL (Specify) [illegible]

22b. DATE THEREOF 2/16/59

22c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY

22d. LOCATION (City, town or county) (State) WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] INC. ADDRESS SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE FEB 16 59

24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2105

00755

Reg Dist No

1 PLACE OF DEATH
a COUNTY: Montgomery
MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland
b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Chevy Chase
d STREET ADDRESS: 4306 Leland Street

INSIDE CITY LIMITS? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Lawrence; Middle: Tudor; Last: Matson

4 DATE OF DEATH: Month: February; Day: 2; Year: 1959

5. SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 25, 1900

9 AGE (If under 1 year, give age in months, days, hours, or minutes): 58 yrs

UNDER 1 YEAR: Months: 8; Days: 7

UNDER 24 HR: Hours: ; Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer

10b KIND OF BUSINESS OR INDUSTRY: U.S. Info. Ag.

11 BIRTHPLACE (State or foreign country): Kansas City, Kansas

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Matthew Lawrence Matson

14 MOTHER'S MAIDEN NAME: Bessie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16 SOCIAL SECURITY NO: 443-24-5843

17 INFORMANT (Address): Gladys Gay Matson (wife)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac arrest — Interval between onset and death: immediate

DUE TO (b): Status postoperative — immediate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Early generalized peritonitis

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18):

20c TIME OF INJURY: Hour a.m. p.m.; Month; Day; Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-3-59

EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2/5/59

22c NAME OF CEMETERY OR CREMATORY: Nat. Mem. Park

22d LOCATION (City, town, or county) (State): Falls Church, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey

ADDRESS: Bethesda, Maryland

24a REC'D BY REGISTRAR: DATE FEB 5 59

24b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please [illegible] pending in pencil in Item 18. Give Pages 1, 2 and 3 to the [illegible] or Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for [illegible] death or to designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS A15ME
BM 2 57

Bethesda 9 days

Suburban

Male White May 25, 1900 Lawrence Tudor Matson

Civil Engineer . . . . . Kansas City

Matthew Lawrence Matson Bessie

No Yes G Ladye Gay Ma

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 F... 2-2-59

1999 **CERTIFICATE OF DEATH**

Reg. Dist. No. 1218

1 PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 39 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cedar Haven Rest Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York, Zone 58
d. STREET ADDRESS: 2565 Marion Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sara Middle: Crandall Last: Maxwell
4. DATE OF DEATH: Month: February Day: 21 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 28, 1874
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Children's Wear
10b. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Bernard Maxwell
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 110-12-6568
17. INFORMANT: Roland P Amateis, Address: 3700 Mass Ave, N.W. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs.
DUE TO (b) Congestive Heart Failure, due to — Weeks
DUE TO (c) Coronary Atherosclerosis And Broncho-pneumonia — Years / 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour o'clock p.m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 9th, 1959, to Feb. 21, 1959, that I last saw the deceased alive on Feb. 20, 1959, and that death occurred at 1:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace R. Mock, M.D. ADDRESS (Street, city or town, state): 7701 Carroll Ave. Tak. Pk, Md. DATE SIGNED: 2/21/59

PHYSICIAN'S NAME (Type):

22a. BURIAL—CREMATION—REMOVAL (Specify): removal
22b. DATE THEREOF: 2/21/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cem.,
22d. LOCATION (City, town, or county) (State): Westchester Co., New York

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C.
24a. REC'D BY REGISTRAR DATE: FEB 24 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2106

CERTIFICATE OF DEATH

Reg. Dist. No. 0208

1 PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN (b): 4 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9612 Cedar Lane, Bethesda

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9612 Cedar Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Ann Last: McMahon
4. DATE OF DEATH: Month: February Day: 7 Year: 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 26, 1883
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.
11. BIRTHPLACE (State or foreign country): Dist. of Columbia
12. CITIZEN OF WHAT COUNTRY: U.S.
13. FATHER'S NAME: William McMahon
14. MOTHER'S MAIDEN NAME: Mary Langan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Lewis Thomas — Address: 9612 Cedar Lane, Beth.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of Breast with generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: 11 years
170 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November, 1958, to Feb 7, 1959, that I last saw the deceased alive on February 6, 1959, and that death occurred at 7 cc A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James W. Egan M.D. ADDRESS (Street, city or town, state): 7720 Wisconsin Ave, Bethesda, Md. DATE SIGNED:
PHYSICIAN'S NAME (Type): James W Egan

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/10/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] H. [illegible] Y, INC. ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE FEB 10 59
24b. REGISTRAR'S SIGNATURE: Arthur L. Mank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

A 20-59 2115

Reg Dist No

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (outside corporate limits, or in a village and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DCA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (Inside corporate limits, write RURAL and give nearest town): North Linthicum
d. STREET ADDRESS: 327 Maple Rd.
YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert Middle: Milfred Last: Meadows
4. DATE OF DEATH: Month: February Day: 6 Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-17-21
9. AGE (In years if 1 or over): 37 yrs. UNDER 1 YEAR: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Excavating + Grading (Self Emp.)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Waynesborough, Pa.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Elmer E Meadows
14. MOTHER'S MAIDEN NAME: Edna Woods
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W. Wil
16. SOCIAL SECURITY NO: (160 16 3739)
17. INFORMANT: Mrs. Marvin Meadows Address: Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractures (two) of vertebral column with spinal cord compression, multiple rib fractures, skull

DUE TO (b) fracture DUE TO Trauma

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

Midshaft fracture of right femur and left hemothorax

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Was struck on back by stump which fell from truck
20c. TIME OF INJURY: Hour 12 40 pm Month Day Year 2-24 1959
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Vacant lot
20f. (City or town) Silver Spring (County) Montg. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒, Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-26-59

22a. BURIAL CREMATION REMOVAL (Spec.): Burial
22b. DATE THEREOF: March 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.
22d. LOCATION (City, town, or county): Glen Burnie, Md. State:

23. FUNERAL DIRECTOR'S SIGNATURE: Richard V. Singleton
ADDRESS: Glen Burnie, Md
24a. RECD BY REGISTRAR DATE: MAR 2 59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please exert the [redacted] writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be delivered to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2107

2108

Reg Dist No

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring

c LENGTH OF STAY IN 1b: 3 yrs

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11503 Highy St

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE: md — b COUNTY: Monty

c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring

d STREET ADDRESS: 11503 Highy St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Leslie — Middle: L. — Last: Mews

4 DATE OF DEATH: Month: Feb — Day: 8 — Year: 1959

5 SEX: male

6 COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 7-8-98

9 AGE (Years last birthday): 60 yrs.

If UNDER 1 YEAR: Months ___ Days ___ If UNDER 24 HRS: Hours ___ Min ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): APPLIANCE REPAIRMAN

10b KIND OF BUSINESS OR INDUSTRY: SEARS

11 BIRTHPLACE (State or foreign country): Canada

12 CITIZEN OF WHAT COUNTRY: Canada

13. FATHER'S NAME: ROBERT T. MEWS

14. MOTHER'S MAIDEN NAME: JANE EXELBY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — If yes, give war or dates of service:

16 SOCIAL SECURITY NO: 577-38-0636

17 INFORMANT: Mrs. Ethel M. Best, 1349 Dewey Ave. — Address: Rochester, N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Tuberculosis

002X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Acute Alcoholism

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour ___ a.m. p.m. — Month ___ Day ___ Year 19___

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-9-59

EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 2/12/59

22c NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY

22d LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

23 FUNERAL DIRECTOR'S SIGNATURE: W. A. E. PUMPHREY, INC.

ADDRESS: SILVER SPRING, MD.

24a REC'D BY REGISTRAR: DATE FEB 1 1960

24b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate in pencil and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be returned for a short period to the Chief of Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2108

CERTIFICATE OF DEATH

Reg. Dist. No. 02181

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7925 Chicago Avenue

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
d. STREET ADDRESS: 7925 Chicago Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JACOB Middle WILLIAM Last MEYERS

4 DATE OF DEATH: Month February Day 18 Year 1959

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 15, 1876
9 AGE (In years last birthday): 82 yrs
If UNDER 1 YEAR: Months | Days
If UNDER 24 HRS.: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant - Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Poland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Bernard Meyers
14 MOTHER'S MAIDEN NAME: Anna Litke

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17 INFORMANT: Address: Mrs. Jennie Meyers 7925 Chicago Ave., S.S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2-3 mo

DUE TO (b) Prostatic Hypertrophy, benign) + Chronic Cystitis — 4-5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Generalized severe arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from Jan 1959, to Feb 18, 1959, that I last saw the deceased alive on Feb 17, 1959, and that death occurred at 10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 8641 Colesville Rd Silver Spring, Md. DATE SIGNED: Feb 16, 1959

PHYSICIAN'S NAME (Type): Blaine Eig, M.D. 8641 Colesville Rd., Silver Spring, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Feb. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: King David Memorial Garden
22d LOCATION (City, town, or county) (State): Falls Church Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: B. Danzansky & Sons ADDRESS: 3501 14th St., N.W.
24a. REC'D BY REGISTRAR: DATE FEB 2 4 9
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2109 **CERTIFICATE OF DEATH** Reg. Dist. No. 1208

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 11 days

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Suburban

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D.C. b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. STREET ADDRESS: 4652 Wisconsin Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Frances Last Mills

4. DATE OF DEATH: Month 2 Day 7 Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-2-77

9. AGE (In years last birthday): 81 yrs.

10. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ~~Thomas B. Lovett~~ ? Mills

14. MOTHER'S MAIDEN NAME: Lovett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: ——

17. INFORMANT: Niece Address: Bertha Brown, 419 Univ. Blvd. E. Silver Spring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIOLE PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) PLEURAL EFFUSION

DUE TO (c) PULMONARY EMBOLISM

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Generalized Arteriosclerosis Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18): —

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 20, 1959 to Feb 7, 1959 that I last saw the deceased alive on 2-7-59, 19____, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: P P Andrews M.D. ADDRESS (Street, city or town, state): 4201 Fessenden St NW DATE SIGNED

PHYSICIAN'S NAME (Type): P P ANDREWS M.D. WASHINGTON D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/10/59

22c. NAME OF CEMETERY OR CREMATORY: Hamilton Va

22d. LOCATION (City, town, or county) (State): Hamilton Va

23. FUNERAL DIRECTOR'S SIGNATURE: Adams Funeral Home ADDRESS: 4746 Wis Ave

24a. RECD BY REGISTRAR DATE FEB 11 '59

24b. REGISTRAR'S SIGNATURE: Anthony E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2015 CERTIFICATE OF DEATH

Reg Dist No 12085

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 419 Park Road

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 419 Park Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROBERT Middle W. Last MILLS

4 DATE OF DEATH: Month February Day 24, Year 1959

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 27, 1891
9 AGE (In years last birthday): 67 yrs
UNDER 1 YEAR: Months 3 Days 27
UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired Foreman
10b KIND OF BUSINESS OR INDUSTRY: Railroad
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John L. Mills
14 MOTHER'S MAIDEN NAME: Margaret V. Butt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
INFORMANT: Mrs. Sadie Johnson-sister-same as 2d — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
420.1
DUE TO
(b) Coronary Thrombosis — 12 hrs
DUE TO
(c) generalized arteriosclerosis — Indefinite

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: old C.V.A.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, not by medical examiner)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month Day Year Hour a. m. p. m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) County (State)

21 I certify that I attended the deceased from Jan. 1, 1953 to 2/24/57 that I last saw the deceased alive on 2/24/57 and that death occurred at 9:16 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Stephen N. Jones M.D.
ADDRESS (Street, city or town, state): Rockville, Md.
DATE SIGNED: 2/24/59
PHYSICIAN'S NAME (Type): Stephen Jones - Rockville, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2/26/59
22c NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
22d LOCATION (City, town, or county, state): Rockville, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a RECD BY REGISTRAR: DATE FEB 25 '59
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 4)
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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2110

Reg Dist No

1 PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (Include corporate limits or RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): X
d. STREET ADDRESS: 4427 Maryland Avenue
e. ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: James; Middle: A; Last: Lyon

4 DATE OF DEATH: Month: February; Day: 1; Year: 19[illegible]

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ WIDOWED ☐ NEVER MARRIED ☐ DIVORCED ☐
8 DATE OF BIRTH: May 7, 1897
9 AGE (In years last birthday): 61 yrs
If UNDER 1 YEAR: Months: 7; Days: 7
If UNDER 24 HRS: Hours: ; Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Clerk
10b KIND OF BUSINESS OR INDUSTRY: Carriers Drug Store
11 BIRTHPLACE (State or foreign country): Minnesota
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Alfred Milton
14 MOTHER'S MAIDEN NAME: Mary Anna Mossburger

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16 SOCIAL SECURITY NO: Unknown
17 INFORMANT: Wife
Address: Martha L. Milton - Same as 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
INTERVAL BETWEEN ONSET AND DEATH: ½ hr.

#20.1

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/15/59

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-18-59
22c NAME OF CEMETERY OR CREMATORY: Parklawn Cem.
22d LOCATION (City, town, or county) (State): Montgomery Co., Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.

24a RECORD BY REGISTRAR: DATE FEB 18 59
24b REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary please [illegible] the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the relatives or [illegible] Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained or [illegible] or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Give pages 1 and 2 with the State Board of Health.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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2111

CERTIFICATE OF DEATH

Reg. Dist. No. 02090

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 1508 44th. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ona — Middle: S. — Last: Moise
4. DATE OF DEATH: Month: Feb. — Day: 15 — Year: 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/14/86 1886
9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: J.H. Spilman
14. MOTHER'S MAIDEN NAME: Margaret Bisinem
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).

PART I. DEATH WAS CAUSE BY IMMEDIATE CAUSE (a) Metastatic Melanoma of Dorsal Spine — INTERVAL BETWEEN ONSET AND DEATH: one month
DUE TO (b) with paraplegia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Primary Melignant Melanoma of scalp — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1) Cord paralysis of urinary bladder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State):

21. I certify that I attended the deceased from 1952, to Feb 15, 1959, that I last saw the deceased alive on Feb 15, 1959, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stewart Chapp M.D. — ADDRESS (Street, city or town, state): 3921 Ingomar St. — DATE SIGNED: Feb 15 '59
PHYSICIAN'S NAME (Type): Stewart Chapp — Wash 15 D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/15/59
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT
22d. LOCATION (City, town, or county) (State): ARLINGTON, VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph F. Lasche Sons — ADDRESS: 3434 17 St N.W. D.C.
24a. REC'D BY REGISTRAR: DATE FEB 17 '59
24b. REGISTRAR'S SIGNATURE: A. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9 '55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2001

CERTIFICATE OF DEATH

Reg. Dist. No. 1209

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN (b): 2-2-59 11:50 pm; 2-4-59 12:35 AM
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4114 Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phoebe; Middle: Ann; Last: Note
4. DATE OF DEATH: Month: February; Day: 4; Year: 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-27-19
9. AGE (In years last birthday): 40 yrs. IF UNDER 1 YEAR: Months: 0; Days: 9; IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): D. C.
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Jack L. Ummons
14. MOTHER'S MAIDEN NAME: Bertie Dickson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Chart — Address: Record Office Washington San & Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
(a) Left cerebral hemorrhage with
DUE TO
(b) Massive subdural hematoma
DUE TO
(c) Probably due to ruptured aneurysm

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — several days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 2, 1959 to Feb 4, 1959, that I last saw the deceased alive on Feb. 3, 1959, and that death occurred at 12:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Bennett A. Porter, Jr. M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 2/4/59

PHYSICIAN'S NAME (Type): Bennett A. Porter, Jr. — 9301 Colesville Rd. Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 2/7/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
22d. LOCATION (City, town, or county) (State): Florence, S. Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 6 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2112

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 14 days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: District of Columbia — COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

d. STREET ADDRESS: 7701 Georgia Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: Estell — Last: MUDD

4. DATE OF DEATH: Month: February — Day: 8 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-18-82

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Charles LOMBARDY

14. MOTHER'S MAIDEN NAME: Rose HAMMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: (Son) Joseph F. MUDD — Address: 225 Grant Ave. Takoma Park, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY — IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

410.0 — DUE TO (b): Arteriosclerotic Heart Disease — 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 1, 19 59, to February 8, 19 59, that I last saw the deceased alive on February 8, 19 59, and that death occurred at 7:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Miale Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital NNMC — DATE SIGNED: 2-8-59

PHYSICIAN'S NAME (Type): A. MIALE Jr. LTMC USN — Bethesda 14 Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-11-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town or county): Arlington — State: Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W.E. Pumphrey — ADDRESS: 843 Georgia Ave. ~~N.W. Wash. D.C.~~ S.S. MD

24a. RECEIVED BY REGISTRAR: DATE FEB 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur [illegible]

Wm. E. Pumphrey Inc. S.S. MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A 5 (4) ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2113 **CERTIFICATE OF DEATH** Reg. Dist. No. 12093

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION 8320 16th Street

7 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring

d. STREET ADDRESS 8320 16th Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Arthur Middle Reuben Last Myers, Sr.

4 DATE OF DEATH Month February Day 25, Year 1959

5 SEX male

6. COLOR OR RACE white

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7/10/95

9 AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Civil Engineer

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) Portsmouth, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Calvin Baysue Myers

14 MOTHER'S MAIDEN NAME Eleanor Essex

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.

17 INFORMANT Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH 15 minutes

DUE TO (b) Coronary Thrombosis — 8 years

DUE TO (c) Arteriosclerosis — Unknown

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month Day Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from July 10 1952, to Feb. 25 1959, that I last saw the deceased alive on Feb. 25 1959, and that death occurred at 6:27 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE O B Wardrop MD MD ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring Md DATE SIGNED 2/25/59

PHYSICIAN'S NAME (Type) W. B. WARDROP MD 837 BONIFANT ST SILVER SPRING MD

22a. BURIAL, CREMATION, REMOVAL (Specify) removal

22b. DATE THEREOF 2/28/59

22c. NAME OF CEMETERY OR CREMATORY West View Cemetery

22d. LOCATION (City, town, or county) Atlanta, Ga. (State)

23. FUNERAL DIRECTOR'S SIGNATURE The D. H. Hines Co. ADDRESS 2901-4 Nat. Ave. Washington D.C.

24a. REC'D BY REGISTRAR DATE FEB 2, 59

24b. REGISTRAR'S SIGNATURE Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2114

CERTIFICATE OF DEATH

00756

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

c. LENGTH OF STAY IN 1b: 3 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 705 RITCHIE AVENUE

d. STREET ADDRESS: 705 RITCHIE AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: H. A. — Last: NAECKER

4. DATE OF DEATH: Month: FEB. — Day: 3 — Year: 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/28/74

9. AGE (In years last birthday): 84 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PIANO TUNER

10b. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AUGUST NAECKER

14. MOTHER'S MAIDEN NAME: KATHERINE BOETTCHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. John G. Lorz, 705 Ritchie Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Septic Bronchopneumonia — Interval between onset and death: 2 days

DUE TO (b): Pulmonary edema — 1 day

DUE TO (c): Hypertensive Cardiovascular Disease — 1 yr

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: 4450

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Abscess Parotid gland rt

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month — Day — Year — Hour — a.m. p.m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 19 54 to Feb. 19 59, that I last saw the deceased alive on Feb 3 19 59, and that death occurred at 10 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Patten MD — ADDRESS (Street, city or town, state): 8641 Colesville Road — DATE SIGNED: 2/3/59

PHYSICIAN'S NAME (Type): RALPH F. PATTEN MD — Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/7/59

22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY

22d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. FINNEY, INC. — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR: DATE FEB 5 59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02094

CERTIFICATE OF DEATH

2115

Reg. Dist. No.

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital give street address OR INSTITUTION): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47
d. STREET ADDRESS: 1624 Kenilworth Avenue, N. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allean — Middle: Lorraine — Last: Neal
4. DATE OF DEATH: Month: February — Day: 25, — Year: 19 59
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 26, 1925
9. AGE (In years last birthday): 33 yrs
IF UNDER YEAR IF UNDER 24 HRS: Months | Days | Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printing Assistant
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Theodore Crawford
14. MOTHER'S MAIDEN NAME: Ada Williams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 241-32-2580
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH
705.4
DUE TO
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
(b) Myocarditis and Pericarditis
DUE TO
(c) Lupus Erythematosus

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 21, 1959 to February 25, 1959, that I last saw the deceased alive on February 25, 19 59, and that death occurred at 2:25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Eugene B. Feigelson M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2/26/59
PHYSICIAN'S NAME (Type): EUGENE B. FEIGELSON, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2-27-59
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City or town or county) (State): Wilson, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: R. N. Horton — ADDRESS: 1322 Yount St. N.W.
24a. RECEIVED BY REGISTRAR: DATE MAR 2 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2116 **CERTIFICATE OF DEATH** Reg. Dist. No. 1206

PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) OLNEY

c. LENGTH OF STAY IN 1b 22 yrs.

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION OLD BALTIMORE ROAD

2 USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OLNEY

d. STREET ADDRESS OLD BALTIMORE ROAD

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First GERTRUDE Middle ELIZABETH Last NICHOLSON

4 DATE OF DEATH Month FEB. Day 19 Year 1959

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 9/6/09 9. AGE (In years at birthday) 49 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) CLERK

10b. KIND OF BUSINESS OR INDUSTRY CO-OP MARKETS

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME THOMAS E. SHAW

14. MOTHER'S MAIDEN NAME EDNA G. BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 220-34-3403

17. INFORMANT Mr. Robert G. Nicholson, Old Baltimore Rd. Olney, Maryland (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis a — INTERVAL BETWEEN ONSET AND DEATH 1 min.

DUE TO (b) Myocardial Infarction acute

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 18 19 53 to 19 FEB 19 59 that I last saw the deceased alive on 16 Feb 1959 and that death occurred at 6:05 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE John B. Ziegler M.D. ADDRESS (Street, city or town, state) Olney, Md DATE SIGNED 19 Feb 59

PHYSICIAN'S NAME (Type) JOHN B. ZIEGLER

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 2/22/59 22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY 22d. LOCATION (City, town, or county) (State) OLNEY, MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE FEB 24 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be re-filed with the registrar prior to burial, cremation, or removal) and in any event within 72 hours after death.

VS A 5 (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2117

02096

Reg. Dist. No.

PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): 1212 Rupert Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. STREET ADDRESS: 1212 Rupert Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle ROBERT NICKOLSON

4. DATE OF DEATH: Month Feb. Day 26, Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 10, 1874

9. AGE (in years last birthday): 84 yrs. IF UNDER 1 YEAR: Months 11 Days 16 IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor-Foreman-Retired

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: ? Nickolson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Wife Inez Osmand Nickolson Address: Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cancer of stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 months

151X

DUE TO (b):

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. IF EITHER, NOTIFY MEDICAL EXAMINER

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month Day Year Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jany 17 1959 to Feby 26 1959 that I last saw the deceased alive on Feby. 26 1959, and that death occurred at 8:30 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: John N. Andrews M.D. ADDRESS (Street, city or town, state): 9601 Colesville Rd. Silver Spring, Maryland DATE SIGNED: 2-27-59

PHYSICIAN'S NAME (Type): JOHN N. ANDREWS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-2-59

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

22d. LOCATION (City, town, or county): Prince George Co., Md. State:

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY, ADDRESS: Bethesda, Md.

24a. RECORDED BY REGISTRAR: DATE MAR 2 59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the burial certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VSA S 4
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Fil[illegible]

2118

CERTIFICATE OF DEATH

Reg. Dist. No. 2057

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Potomac
c. LENGTH OF STAY IN 3b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ropine Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 6005 Grosvenor Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: A. — Middle: John — Last: Nilsen
4. DATE OF DEATH: Month: February — Day: 14 — Year: 1959
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 26, 1877
9. AGE (in years if over 1 birthday): 80 81 yrs — IF UNDER 1 YEAR: Months: 5 Days: 18 — IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Christian Nielsen
14. MOTHER'S MAIDEN NAME: ? Andersen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Martha T. Ford-same as 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Cancer [illegible] — 12 mos
DUE TO
(b) Cerebrovascular disease — 2 + yrs
DUE TO
(c)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month: Day: Year: 19 — Hour: a. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 21, 19[illegible], to Jan. 23, 1921, that I last saw the deceased alive on Jan. 12, 1921, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED: [illegible]

PHYSICIAN'S NAME (Type): HERBERT MARTYN JR. — [illegible] — [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/16/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 18 '59
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2119

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 6 hrs. 42 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1500 Arlington Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James — Middle: — Last: NIELSEN

4 DATE OF DEATH: Month: February — Day: 15 — Year: 1959

5 SEX: Male
6 COLOR OR RACE: Caucasian
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 4-2-92
9 AGE In years (last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b KIND OF BUSINESS OR INDUSTRY: U.S.Navy
11 BIRTHPLACE (State or foreign country): Denmark
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Niels Peter NIELSEN
14 MOTHER'S MAIDEN NAME: Margaret SKOV

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI & WWII
16 SOC. AL SECURITY NO: 577-38-0216
17 INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Paroxysmal Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
(b) Arteriosclerotic Heart Disease — 5 years
DUE TO
(c)

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last. 427

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Extensive Myocardial Infarction July 1958

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from February 15, 1959, to February 15 1959, that I last saw the deceased alive on February 15, 1959, and that death occurred at 7:57A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-16-59

PHYSICIAN'S NAME (Type): F. S. CALDWELL, LT, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-20-59
22c NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
22d LOCATION (City, town or county) (State): ARLINGTON, VIRGINIA

23 FUNERAL DIRECTOR'S SIGNATURE: M. F. Wade — ADDRESS: 57 W.W. Chambers CC
24a REC'D BY REGISTRAR: DATE FEB 19 '59
24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar or for burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2120

CERTIFICATE OF DEATH

Reg. Dist. No. 12093

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Layhill

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seymour Nursing Home

d. STREET ADDRESS 2032 Belmont St. N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Helen Middle D. Last Norfleet

4. DATE OF DEATH Month Feb. Day 9, Year 1959

5. SEX female

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3/20/80

9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk Treasury Dept.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Binghamton, N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME P. Donald Driscole

14. MOTHER'S MAIDEN NAME Anna Louise Robertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Hadwen Hiller Address 100 Myrtle St. Manchester, N.H.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

DUE TO (b) Arterio-Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Nephritis, Chronic — 5 yrs

Arterio-Sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/17/48, 19____ to 2/9/58, 19____ that I last saw the deceased alive on 2/8/59, 19____, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James A. O'Rourke M.D. ADDRESS (Street, city or town, state) 4501 Conn. Ave. N.W. DATE SIGNED

PHYSICIAN'S NAME (Type) James A O'Rourke M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) burial

22b. DATE THEREOF 2/13/59

22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.

22d. LOCATION (City, town, or county) Ft. Myer, Va. (State)

23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE FEB 13 1959

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director or page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2002 **CERTIFICATE OF DEATH** 00757

Reg. Dist. No.

PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.

c. LENGTH OF STAY IN 1b: 8 years

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. STREET ADDRESS: 3622 Park Heights

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ethel Middle: (Rank) Last: Dover

4. DATE OF DEATH: Month: Feb. Day: 2 Year: 19[illegible]

5. SEX: Female

6. COLOR OR RACE: Jewish

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 10-19-87

9. AGE (In years last birthday): 71 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Hyman Cohen

14. MOTHER'S MAIDEN NAME: Hannah Lundbourg (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOC. SEC. NO.: NONE

17. INFORMANT: Pt's Chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSE BY IMMEDIATE CAUSE (a): [illegible]

DUE TO: 301K

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: (b) [illegible]

DUE TO: (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (FURTHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-2-59, 19[illegible] to [illegible] 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 3:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 2-4-59

PHYSICIAN'S NAME (Type): Kimmit Hare, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-4-59

22c. NAME OF CEMETERY OR CREMATORY: Natl Mem Park

22d. LOCATION (City, town, or county): Falls Church (State): Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Sullivan Funeral Home ADDRESS: 4217 Georgia Ave

24a. REC'D BY REGISTRAR DATE: Feb 4 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS AIS (4) ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2121

Reg. Dist. No. 2160

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural

c. LENGTH OF STAY IN 1b: 12 hr 5 min

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

7 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

d. STREET ADDRESS: 5281 Inglin St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Infant Middle: Nuckols Last:

4 DATE OF DEATH: Month: Feb Day: 12 Year: 1959

5 SEX: Male 6. COLOR OR RACE: White 7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Feb. 12

9 AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: 1 IF UNDER 24 HRS: Hours: Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? US

13 FATHER'S NAME: William Edwin Nuckols

14. MOTHER'S MAIDEN NAME: Mary Inez Spong

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: None

17 INFORMANT: William E. Nuckols, Jr.-same as 2d Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Atelectasis, Neonatal — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

762.5

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (c): Prematurity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month Day Year Hour a.m. p.m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Feb. 11, 1959 to Feb. 12, 1959 that I last saw the deceased alive on Feb. 12, 1959, and that death occurred at 10:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip H. Varner, M.D. ADDRESS (Street, city or town, state): 10620 Georgia Ave., Silver Spring, Md. DATE SIGNED: 2/12/59

PHYSICIAN'S NAME (Type): Philip H. Varner 10620 Ga. Ave. Silver Spring, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2/16/59

22c NAME OF CEMETERY OR CREMATORY: Arlington National

22d LOCATION (City, town, or county) (State): Arlington, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 1 9 59

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2122

CERTIFICATE OF DEATH

Reg. Dist. No. 02141

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 9 yrs 4½ mo
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Asbury Methodist Home for the Aged

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lydia Middle: Lost: OURSLER
4. DATE OF DEATH: Month: Feb Day: 24 Year: 1954
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-22-1869
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kept house
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Manchester, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Edward Oursler
14. MOTHER'S MAIDEN NAME: Juilann Weaver
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Asbury Methodist Home, Gaithersburg, Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial failure
DUE TO
(b) Cancer of rectum & metastasis — 6-12-57
DUE TO
(c)

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 12, 1955, to Feb 24, 1954, that I last saw the deceased alive on Feb 23, 1954, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sarah E. Glover M.D. ADDRESS (Street, city or town, state): 11125 CEDAR LANE KENSINGTON, MD DATE SIGNED: 2-24-59

PHYSICIAN'S NAME (Type): Sarah E. Glover

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-26-59
22c. NAME OF CEMETERY OR CREMATORY: Mizpah Cemetery
22d. LOCATION (City, township, county): Manchester (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Forest E. Harbaugh ADDRESS: Gaithersburg Md.
24a. RECEIVED BY REGISTRAR: DATE FEB 26 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2123 **CERTIFICATE OF DEATH** Reg. Dist. No 02102

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville (Rural)
c. LENGTH OF STAY IN 1b: 14yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: LULA — Middle: — Last: OWENS
4 DATE OF DEATH: Month: Feb. — Day: 23, — Year: 1959
5 SEX: Female
6 COLOR OR RACE: Colored
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Nov. 15, 1885
9 AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HR.: Hours: — Min:
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Nelson
14 MOTHER'S MAIDEN NAME: Irene Nelson
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: Solomon Owens — Address: Poolesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
331X
DUE TO
(b) Hypertension — 6 mo.
DUE TO
(c)

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month: Day: Year: 19 Hour: a. m. p. m.
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Oct. 19 58 to Feb 23 1959 that I last saw the deceased alive on Feb. 21 1959 and that death occurred at 4:00 P M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. Vernon E. Martens MD — ADDRESS (Street, city or town, state): Germantown, Md — DATE SIGNED: 2-23-59

PHYSICIAN'S NAME (Type): Dr. Vernon E. Martens.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2/28/59
22c NAME OF CEMETERY OR CREMATORY: Elijah,
22d LOCATION (City, town, or county) (State): Poolesville, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sunderlin — ADDRESS: Rockville, Md.
24a RECD BY REGISTRAR: DATE 4 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Kraus

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No 02103

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 11 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10517 Seven Locks Rd

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville (rural)
d. STREET ADDRESS: 10517 Seven Locks Rd
ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: M. — Last: Payne
4. DATE OF DEATH: Month: Feb — Day: 2 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-9-1883
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months — IF UNDER 24 HRS: Days, Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Phillip Payne
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Florence Payne (wife) — Address: Star 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
420.1
(Enter only one cause per line) Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐ Homicide ☐ undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
DATE SIGNED: 2-2-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/5/59
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Park
22d. LOCATION (City, town, or county): Rockville, Md (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md
24a. REC'D BY REGISTRAR: DATE FEB 9 '59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Funeral Director. Page 5 may be retained for files. A shaded be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR. Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2124

CERTIFICATE OF DEATH

Reg. Dist. No. 02104

1 PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b 18 months
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 808 HERON DRIVE

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS 808 HERON DRIVE
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print) First MATHILDA Middle MARIE Last PEACOCK
4 DATE OF DEATH Month FEB. Day 16 Year 1959
5 SEX FEMALE 6 COLOR OR RACE WHITE 7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH 11/18/01
9 AGE (In years last birthday) 57 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) RECEPTIONIST
10b KIND OF BUSINESS OR INDUSTRY REAL ESTATE
11 BIRTHPLACE (State or foreign country) PENNSYLVANIA
12 CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME MICHAEL SCHAFF
14. MOTHER'S MAIDEN NAME CATHERINE YAGO
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16 SOC AL SECURITY NO YES
17 INFORMANT Mr. Francis A. Peacock, 808 Heron Drive Silver Spring, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of colon with extensive ideoli jel spread — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
DUE TO (b)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work [ ] Not while at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 1/8, 1957, to 2/16, 1959, that I last saw the deceased alive on 2/14/, 1959, and that death occurred at 5:20A M, from the causes and on the date stated above

ACTUAL SIGNATURE Harold F. McCann M.D. ADDRESS (Street, city or town, state) 3355 - 16th St NW DATE SIGNED
PHYSICIAN'S NAME (Type) HAROLD F McCANN Washington D.C.

22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 2/18/59
22c NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY
22d LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD. (State)

23 FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.
24a. RECEIVED BY REGISTRAR DATE FEB 18 59
24b RECISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2125

CERTIFICATE OF DEATH

Reg. Dist No 215

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c LENGTH OF STAY IN this place: 5 hrs 52 min
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)
a STATE: Maryland
b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indianhead
d STREET ADDRESS: 3 Cogswell Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Jack — Middle: Alen — Last: PEREZ
4 DATE OF DEATH: Month: February — Day: 14 — Year: 1959
5 SEX: Male
6 COLOR OR RACE: Caucasian
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 13 February 1959
9 AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 5 — Min: 52
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.
13 FATHER'S NAME: Edmund A PEREZ
14 MOTHER'S MAIDEN NAME: Judith Ann YANCEY
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16 SOCIAL SECURITY NO: none
17 INFORMANT: (F) Edmund A. Perez, same as #2 above — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Anoxia
DUE TO (b): Prematurity
DUE TO (c):
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 5 hrs. 52 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 13 February, 1959, to 14 February, 1959, that I last saw the deceased alive on 14 February, 1959, and that death occurred at 2:50A M from the causes and on the date stated above.

ACTUAL SIGNATURE: George J. A. Magnant M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-14-59

PHYSICIAN'S NAME (Type): George J. A. MAGNANT, LT, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
22b. DATE THEREOF: 2/16/59
22c NAME OF CEMETERY OR CREMATORY: Valhalla
22d LOCATION (City, town, or county) (State): Godfrey, Illinois

23 FUNERAL DIRECTOR'S SIGNATURE: Ernest Hardman — ADDRESS: Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. D.C.
24a RECEIVED BY REGISTRAR: DATE FEB 18 '59
24b REGISTRAR'S SIGNATURE: Gertrude S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2120

00758

Reg Dist No

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (outside corporate limits write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN this place: 2 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 3301 Turner La

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Mass
b. COUNTY: Hampshire
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Florence
d. STREET ADDRESS: 62 Middle St.
e. IS THIS PLACE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace — Middle: Anna — Last: Philips
4. DATE OF DEATH: Month: Feb — Day: 1 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-9-1886
9. AGE (In years last birthday): 72 yrs
10. IF UNDER 1 YEAR: Months 10 — Days 22 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Mass
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chas Philips
14. MOTHER'S MAIDEN NAME: Phebe A. Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOC. SEC. SECURITY NO.: 015-26-1441
17. INFORMANT: Mrs H. S. Goodwin — Address: Stow 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary occlusion — NUMBER OF ONSET AND DEATH: sudden

DUE TO (b)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-1-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit 2/2/59
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Oak Grove
22d. LOCATION (City, town, or county) (State): Springfield, Mass.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 4 59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 in the June issue of the Page 4 should be sent to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or as designated agent prior to burial, cremation or removal and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2127 **CERTIFICATE OF DEATH** 2166

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 32 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5 Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 12 Manchester Place

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ilona Middle: (None) Last: Pint

4. DATE OF DEATH: Month: February Day: 6, Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 23, 1925

9. AGE (In years last birthday): 33 yrs

If UNDER 1 YEAR: Months: Days: If UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manicurist

10b. KIND OF BUSINESS OR INDUSTRY: Beauty Salon

11. BIRTHPLACE (State or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? Hungary

13. FATHER'S NAME: Bela Szahali

14. MOTHER'S MAIDEN NAME: Anna Muller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown. If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure - aspiration of vomitus — INTERVAL BETWEEN ONSET AND DEATH: 10 Minutes

DUE TO (b) Intestinal obstruction — 6 Weeks

DUE TO (c) Epidermoid carcinoma of cervix uteri - Status - post total pelvic exeneration with recurrence.

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 5, 1959 to February 6, 1959, that I last saw the deceased alive on February 6, 1959, and that death occurred at 1:00a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 2-6-59

PHYSICIAN'S NAME (Type): Marvin M. Romsdahl, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]

22b. DATE THEREOF: 2-10-59

22c. NAME OF CEMETERY OR CREMATORY: [illegible]

22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: [illegible]

24a. RECEIVED BY REGISTRAR: DATE FEB 10 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9-55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

212S

CERTIFICATE OF DEATH

Reg Dist. No 112107

PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 1965 Rosemary Hills Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. STREET ADDRESS: 1965 Rosemary Hills Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henrietta Middle: Last: Plotnick

4. DATE OF DEATH: Month: Feb. Day: 22 Year: 1959

5. SEX: Female 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1893 9. AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife 10b. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): New York 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Pincus Wollner 14. MOTHER'S MAIDEN NAME: Rae Rosenfeld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service): 16. SOCIAL SECURITY NO: 17. INFORMANT: Mrs Shirley Jacobs Address: Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure (Cancer Metastases) — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b) THYROID CANCER — 8 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Metastatic disease To Lungs, Brain and Bone

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/5, 1959, to 2/22, 1959, that I last saw the deceased alive on 2/22, 1959, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Max Sherer M.D. M.D. ADDRESS (Street, city or town, state): 2025 East West Hwy Silver Spring Md DATE SIGNED: 3/22/59

PHYSICIAN'S NAME (Type): Dr. Max Sherer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: Feb. 24, 1959 22c. NAME OF CEMETERY OR CREMATORY: Wellwood Cemetery 22d. LOCATION (City, town, or county) (State): Farmingdale, L.I. N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: B. Dauzansky & Sons ADDRESS: Wash. D.C. 24a. RECD BY REGISTRAR DATE: FEB 24 1959 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be presented with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) ISM 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2129

CERTIFICATE OF DEATH

Reg. Dist No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 45 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Rt. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Charles — Middle: (none) — Last: PRATHER

4 DATE OF DEATH: Month: February — Day: 13 — Year: 1959

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8 DATE OF BIRTH: 3-16-13

9 AGE (In years on last birthday): 40 yrs

IF UNDER 1 YEAR / IF UNDER 24 HR: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator

10b KIND OF BUSINESS OR INDUSTRY: NNMC, Bethesda, Md.

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13 FATHER'S NAME: Howard PRATHER

14 MOTHER'S MAIDEN NAME: Rosie LANCASTER

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes WWII

16 SOCIAL SECURITY NO: 219-01-7383

17 INFORMANT: (W) Mrs. Rosie Prather, same as 12 above — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 45 min
420.0
DUE TO (b): Arteriosclerotic heart disease — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (If either, notify Medical Examiner)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from February 13, 1959, to February 13, 1959, that I last saw the deceased alive on February 13, 1959, and that death occurred at 5:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature], M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-13-59

PHYSICIAN'S NAME (Type): M. R. PLAUT, LT, MC, USN — Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2-17-59

22c NAME OF CEMETERY OR CREMATORY: Arlington National

22d LOCATION (City, town, or county) (State): Arlington, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Robert Snowden Funeral Home, Rockville, Md.

24a REGISTRAR — DATE: FEB 16 59

24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2130

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN (b): 14 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Florida — b. COUNTY: Lee

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Myers

d. STREET ADDRESS: P.O. Box 1125

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Edward — Last: PRAYTOR

4. DATE OF DEATH: Month: February — Day: 3 — Year: 1959

5. SEX: Male — 6. COLOR OR RACE: Caucasian — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-8-21

9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John PRAYTOR

14. MOTHER'S MAIDEN NAME: Edna GILCHRIST

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): Yes — WWII-KOREAN

16. SOCIAL SECURITY NO.:

17. INFORMANT: (W) Mrs. Jeanne Praytor, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Glioblastoma multiforme — INTERVAL BETWEEN ONSET AND DEATH: 7 mos.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 20 1959 to February 3 1959, that I last saw the deceased alive on February 3 1959, and that death occurred at 9:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. W. Wood MD — M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC. — DATE SIGNED: 2-4-59

PHYSICIAN'S NAME (Type): M. W. WOOD, LCDR, MC, USN — Bethesda 14, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2-9-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county): Arlington — (State): Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: R.A. Pumphrey Funeral Home, Bethesda, Md.

24a. RECORD BY REGISTRAR — DATE: [illegible]

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2131

Reg. Dist. No. 2110

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 5 WKS
d. NAME OF HOSPITAL (If not in hospital give street address), OR INSTITUTION Leland Garden Sanitarium

2 USUAL RESIDENCE (Where deceased ved if institution, Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton (Rural)
d. STREET ADDRESS Route #2 Box #178
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Cynthia Middle: Rachael Last: Raber
4. DATE OF DEATH Month: Feb Day: 17 Year: 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒
8. DATE OF BIRTH 6-14-1882
9. AGE (In years last birthday) 76 yrs
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At home
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Joseph Bane
14. MOTHER'S MAIDEN NAME Priscilla York
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO None
17. INFORMANT Willis E. Raber Address Clinton Md Route #2 Box #178

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Lower Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 da
DUE TO
(b) Carcinoma Throat & Intestines — 6 mo +
DUE TO
(c) Tracheotomy — 3 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 12, 1959 to Feb 17, 1959 that I last saw the deceased alive on Feb 13, 1959, and that death occurred at 6:40 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE Robert T. Thibadeau M.D. — ADDRESS (Street, city or town, state) 10109 Concord St. — DATE SIGNED 2-12-59

PHYSICIAN'S NAME (Type) Robert T. Thibadeau Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-21-1959
22c. NAME OF CEMETERY OR CREMATORY Catholic Vicar Cat. Cl
22d. LOCATION (City, town, or county) (State) VA

23. FUNERAL DIRECTOR'S SIGNATURE C. C. Chambers Co. — ADDRESS 5114 Size St.
24a. REC'D BY REGISTRAR DATE FEB 20 '59
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2132 **CERTIFICATE OF DEATH**

Reg. Dist No. 2111

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Gaithersburg
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Asbury Methodist Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown 2105.2
d STREET ADDRESS: 131 E. Washington St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Hester Raff — Middle: Virginia — Last: Raff
4 DATE OF DEATH: Month: Feb — Day: 9 — Year: 1959
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Oct. 1st, 1868
9 AGE (In years last birthday): 90 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Garrett Co. near Oakland
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: Philip Doffort
14 MOTHER'S MAIDEN NAME: Rachel Miller
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT: Asbury Methodist Home — Address: Gaithersburg Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial failure acute
DUE TO (b) Cerebral vascular accident
DUE TO (c) hypertensive Arteriosclerosis Heart disease
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 1-31-59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 4-18, 1956 to 2-9, 1959, that last saw the deceased alive on 2-9 1959, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sarah E. Glover M.D. — ADDRESS (Street, city or town, state): 10128 Cedar Lane Hampton Md. — DATE SIGNED: 2-9-59

PHYSICIAN'S NAME (Type): Sarah E. Glover, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-12-59
22c NAME OF CEMETERY OR CREMATORY: Rose Hill
22d LOCATION (City, town, or county): Hagerstown — (State): Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Yantus — ADDRESS: Gaithersburg Md.
24a RECEIVED BY REGISTRAR: FEB 11 59 — DATE
24b REGISTRAR'S SIGNATURE: C. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2133 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 2112

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown R-1
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Md R-27 m cedar grove

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown R-1
d. STREET ADDRESS: Md R-27-

IN A ... YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wanda — Middle: Jean — Last: Ramsburg
4. DATE OF DEATH: Month: Feb — Day: 19 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-23-57
9. AGE (In years last birthday): 1 yrs
IF UNDER 1 YEAR: Months 5 Days 24
IF UNDER 24 HRS.: Hours ... Min ...
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Charles Ramsburg
14. MOTHER'S MAIDEN NAME: Mary Shaw
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):
16. SOC. SECURITY NO.:
17. INFORMANT: Mary Ramsburg (mother) — Address: Ster ...

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): upper Respiratory Defection — 1 wk
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):
20c. TIME OF INJURY: Hour ... a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Bioschart — M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2-18-59

EXAMINER'S NAME (Type): FRANK J. BIOSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: Derwood
22d. LOCATION (City, town, or county) (State): Derwood, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. McSwerth — ADDRESS: Damascus, Md.
24a. RECEIVED BY REGISTRAR: DATE: FEB 2 ...
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute it in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSME 5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00759

2003 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK

c. LENGTH OF STAY IN 1b 68 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL

d. STREET ADDRESS 6908 WESTMORELAND AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: HENRY Middle: GORMAN Last: RAY

4. DATE OF DEATH Month: FEBRUARY Day: 3 Year: 1959

5. SEX: MALE 6. COLOR OR RACE: WHITE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 21, 1885

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LETTER CARRIER

10b. KIND OF BUSINESS OR INDUSTRY: U. S. POST OFFICE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EMORY F. C. RAY

14. MOTHER'S MAIDEN NAME: ELIZABETH ELLEN WARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. Florence Ray, 6908 Westmoreland Ave. ~~Takoma Park, Maryland~~ Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1½ mos.

DUE TO

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

(b) Myocardial Infarction — 2 mos.

DUE TO

(c) Coronary Artery Disease — 2-6 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 5 1950, to Feb. 2 1959, that I last saw the deceased alive on Feb. 1 1959, and that death occurred at 7 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sanford J. Randall M.D. ADDRESS (Street, city or town, state): 3636 16 ST. N.W. DATE SIGNED: 2/3/59

PHYSICIAN'S NAME (Type): SANFORD J. RANDALL, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/5/59

22c. NAME OF CEMETERY OR CREMATORY: UNION CEMETERY

22d. LOCATION (City, town, or county) (State): BURTONSVILLE, MONTGOMERY CO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WALTER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.

24a. RECEIVED BY REGISTRAR DATE: FEB 5 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9'55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2134 **CERTIFICATE OF DEATH** 00760

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: MONTGOMERY MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c LENGTH OF STAY IN (b): 29 YRS
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: MARYLAND
b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d STREET ADDRESS: 2025 GLEN ROSS ROAD
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First LOTTIE Middle M Last REDMOND

4 DATE OF DEATH: Month [illegible] Day 4 Year 19 54

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: NOV 11, 1886
9 AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): W.T COUNTER RETIRED
10b KIND OF BUSINESS OR INDUSTRY: US GOVT
11 BIRTHPLACE (State or foreign country): WASH, D.C.
12 CITIZEN OF WHAT COUNTRY? USA.

13 FATHER'S NAME: CHARLES SHORE
14 MOTHER'S MAIDEN NAME: MARGARET

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: NONE
17 INFORMANT: MARGARET Y SHAW Address: 2025 GLEN ROSS RD SIL SPG MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral [illegible]
581.0
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part of item 18)

20c TIME OF INJURY Month Day Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from [illegible], 19 55 to [illegible], 19 54 that I last saw the deceased alive on [illegible], 19 54, and that death occurred at 2:45 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED 2/4/54

PHYSICIAN'S NAME (Type) [illegible]

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: 2-7-54
22c NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEM
22d LOCATION (City, town, or county) (State): WEBSTER ST WASH DC

23 FUNERAL DIRECTOR'S SIGNATURE: W.W CHAMBERS Co
ADDRESS: 1100 CHAPIN ST NW
24a RECEIVED BY REGISTRAR DATE
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2135 **CERTIFICATE OF DEATH** 2113

Reg Dist No. 215

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Puerto Rico
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ramey Air Force Base
d. STREET ADDRESS: APO 845 c/O PM, New York, N.Y.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Patrick — Middle: Sean — Last: REEVES
4 DATE OF DEATH: Month: February — Day: 19 — Year: 1959
5 SEX: Male
6 COLOR OR RACE: Caucasian
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 10-30-58
9 AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 3, Days 20 — IF UNDER 24 HRS: Hours, Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b KIND OF BUSINESS OR INDUSTRY: - - - - -
11 BIRTHPLACE (State or foreign country): Puerto Rico
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: Clark A. REEVES
14 MOTHER'S MAIDEN NAME: Margaret CAYLOR
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (For men or veterans) No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: None
17 INFORMANT: (F) Clark A. Reeves, EM1, USN — Address: Naval Med. Res. Inst Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
(a) Myelomeningocele — INTERVAL BETWEEN ONSET AND DEATH: 3 mo 20 days
DUE TO
(b) hydrocephalus
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS A TOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year, Hour a. m. p. m.
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from February 11, 1959 to February 19, 1959, that I last saw the deceased alive on February 19, 1959, and that death occurred at 1:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Matthew W. Wood MD — M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital — DATE SIGNED: 2-20-59

PHYSICIAN'S NAME (Type): Matthew W. WOOD, LCDR, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
22b DATE THEREOF: 2-21-59
22c NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town or county) (State): Illinois
23 FUNERAL DIRECTOR'S SIGNATURE: Ernest W. Adams
Adams Funeral Home, 4748 Wisc. Ave, NW, Wash. DC
24a RECD BY REGISTRAR: DATE FEB 24 59
24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be relea[illegible] hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event with in 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2136

CERTIFICATE OF DEATH

Reg Dist. No 211

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Dickerson
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Dickerson,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Luther Middle Alonza Lost Renneberger
4 DATE OF DEATH: Month Feb. Day 17 Year 1959

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: April 26-1882
9 AGE (In years last birthday): 76
If UNDER 1 YEAR: Months | Days | If UNDER 24 HRS: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farm owner
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY: U.S

13 FATHER'S NAME: Robert S. Renneberger
14 MOTHER'S MAIDEN NAME: Virginia Eader

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT: Robert Renneberger, Dickerson, Maryland — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months

154X

DUE TO (b) Cancer of the rectum — 4 years

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month Day Year Hour p. m. p. m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 24 January, 1952 to 17 Feb., 1959, that I last saw the deceased alive on 17 January, 1959, and that death occurred at 7.30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon M. Smith, M.D.
ADDRESS (Street, city or town, state): Barnesville, Md.
DATE SIGNED: 18 Feb 59
PHYSICIAN'S NAME (Type): Gordon M. Smith

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2/20/59
22c NAME OF CEMETERY OR CREMATORY: Mt Olivet
22d LOCATION (City, town, or county) (State): Frederick Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton
ADDRESS: Barnesville, Md.
24a REC'D BY REGISTRAR: DATE FEB 24 '59
24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 10-57

1/

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2137 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02115

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 903 Patton Dr

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 903 Patton Dr
ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eugene; Middle: Clarence; Last: Rice

4. DATE OF DEATH: Month 2 Day 10 Year 1959

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-22-67
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): M. D.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. Y.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: David Q. Rice
14. MOTHER'S MAIDEN NAME: Lydia Coffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOC. SEC. NO.: none
17. INFORMANT: Eugene C. Rice, Address: 1816 Sherwood Rd, Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO (b)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: Sudden
Found dead in basement floor
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month Day Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart
M.D. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
DATE SIGNED: 2-10-59

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2/14/59
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR: FEB 1 0 59 DATE
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 of the Funeral Director's Page 4 should be returned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a bar at trans.? permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS-A 5ME
5M 2-57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1211

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 5501 Charles Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 5501 Charles Street
e. INSIDE CORPORATE LIMITS: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clifford; Middle: R.; Last: Ricketts
4. DATE OF DEATH: Month: Feb.; Day: 8; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 3, 1903
9. AGE (In years last birthday): 55
If UNDER 1 YEAR: Months: 11; Days: 5; If UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C. P. A.
10b. KIND OF BUSINESS OR INDUSTRY: Accounting
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: David Ricketts
14. MOTHER'S MAIDEN NAME: Maude Fisher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mildred T Ricketts-Item # 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary occlusion — Interval between onset and death: sudden
420.1
DUE TO (b)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.
20d. INJURY OCCURRED: White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brosenart M.D.
NAME (Type): FRANK J BROSENART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-8-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/11/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 11 '59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in part I in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2 57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No 2117

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 25 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 933 Grayce Lane

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 933 Grayce Lane
e. INSIDE CORPORATE LIMITS: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Geraldine Evelyn Riggs (First, Middle, Last)
4. DATE OF DEATH: Month 2, Day 17, Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-25-1897
9. AGE: 61 yrs
IF UNDER YEAR: Months, Days
IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm Gray
14. MOTHER'S MAIDEN NAME: Rose Bowman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Marjorie Blevins — Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and my opinion as to death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brosehart, M.D.
EXAMINER'S NAME (Type): FRANK J. Brosehart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-17-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/20/59
22c. NAME OF CEMETERY OR CREMATORY: ST. MARY'S CEMETERY
22d. LOCATION (City, town, or county) (State): ROCKVILLE, MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC.
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE FEB 9
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1SME
SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2140

CERTIFICATE OF DEATH

Reg. Dist. No. 0211

1 PLACE OF DEATH
a. COUNTY: Montgomery County, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington, Maryland
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kensington Gardens Sanitarium

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10103 McKenny ~~Ave.~~ ST. Silver Spring, Md.
d. STREET ADDRESS: 10103 McKenny ~~Ave~~ ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Pinkney Last: Roberts SR.
4. DATE OF DEATH: Month: February Day: 23 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 31, 1885/1886
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): District Manager, Air-Reduction Sales Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Prince George Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William W.W. Roberts
14. MOTHER'S MAIDEN NAME: Elesa Weems
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 417-03-5908
17. INFORMANT: Mrs. Wm. P. Roberts Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cancer of tongue
163X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 7 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 19 56, to Feb. 23, 1959, that I last saw the deceased alive on Feb. 22, 1959, and that death occurred at 7 30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert S. McCeney M.D.
ADDRESS (Street, city or town, state): ROBERT S. McCENEY M.D. MAIN ST. LAUREL, MD.
DATE SIGNED: 2/23/59
PHYSICIAN'S NAME (Type): ROBERT S. McCENEY, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 25, 1959
22c. NAME OF CEMETERY OR CREMATORY: St. Barnabas Cemetery
22d. LOCATION (City, town, or county) (State): Prince George's County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc.
ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2004 **CERTIFICATE OF DEATH** Reg. Dist. No. 00761

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 30 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7408 - BALTIMORE AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 7408 - BALTIMORE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELEANOR Middle E. Last ROWAN
4. DATE OF DEATH: Month 2 Day 4 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-14-72
9. AGE (In years last birthday): 86 yrs
If UNDER 1 YEAR: Months Days
If UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVT
11. BIRTHPLACE (State or foreign country): PHILA. PA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM BARR
14. MOTHER'S MAIDEN NAME: MARY FALBEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: —
17. INFORMANT: JOSEPH J. ROWAN Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO (b) arteriosclerotic heart disease — 10 yrs

DUE TO (c) generalized arteriosclerosis — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1957, to February, 1957, that I last saw the deceased alive on February 4, 1959, and that death occurred at 12:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 7852 16th St. N.W. DATE SIGNED: 2/7/59

PHYSICIAN'S NAME (Type): A. F. Kreuzburg Wash 12 D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-7-59
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collins ADDRESS: 3821-14th St. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR: DATE FEB 5 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2141 — Reg. Dist. No. 2119

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whitesburg
d. STREET ADDRESS: (none)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Marie — Middle: Hazel — Last: Sandlin

4 DATE OF DEATH: Month: February — Day: 24, — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: September 26, 1919
9 AGE (In years on last birthday): 39 yrs
If UNDER 1 YEAR: Months — Days
If UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): Kentucky
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Riley Adams
14 MOTHER'S MAIDEN NAME: Ellen Kinser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO: 400-16-9919
17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Subacute Endocarditis, Mitral Valve.
DUE TO: Rheumatic Heart Disease, Mitral Valvulitis:
(b) Status Postoperative Repair, 1958
DUE TO:
(c) Bronchopneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month — Day — Year — Hour — a. m. p. m.
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from February 18, 1959 to February 24, 1959, that I last saw the deceased alive on February 24, 1959, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leon I. Goldberg M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2/25/59
PHYSICIAN'S NAME (Type): LEON I. GOLDBERG, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2/25/59
22c NAME OF CEMETERY OR CREMATORY:
22d LOCATION (City, town, or county) (State): Whitesburg, Va.

23 FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.,
ADDRESS: 2901 14th St. N.W., Wash,D.C
24a. REC'D BY REGISTRAR: DATE FEB 26 '59
24b REGISTRAR'S SIGNATURE: Arthur P. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2005 CERTIFICATE OF DEATH

Reg. Dist. No. 0214

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sani + Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 2024 So. 5th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Robert; Last: Saunders
4. DATE OF DEATH: Month: 3; Day: 16; Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-2-78
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ROUTEMAN (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Elite Laundry
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: John Saunders
14. MOTHER'S MAIDEN NAME: Sarah Keels
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-01-6525
17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause for a, b, and c.]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Vascular Occlusion — Interval between onset and death: 10 days
DUE TO (b): Arteriosclerosis — 6 yrs.
Conditions if any which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/19/55 to 2/10/57, that I last saw the deceased alive on 2/14/57, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 7600 Carroll Ave — DATE SIGNED: 2/16/57
PHYSICIAN'S NAME (Type): W. F. McNeill — Takoma Park, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/12/59
22c. NAME OF CEMETERY OR CREMATORY: Geo. Wash. Mem. Cemetery
22d. LOCATION (City, town, or county) (State): Prince George County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: W. R. E. HUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

212

2142

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2917 Columbia Blvd.

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9205 2nd. Ave.

INSIDE CITY LIMITS ON A FARM: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Calvin W. Middle Schaeffer Last
4. DATE OF DEATH: Month Feb. Day 24 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1894
9. AGE (In years last birthday): 64 yrs.
If under 1 year: Months ___ Days ___
If under 24 hrs.: Hours ___ Min ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U.S. NAVY Lt. Commander
11. BIRTHPLACE (State or foreign country): FREDERICK, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JASPER E. SCHAEFFER
14. MOTHER'S MAIDEN NAME: SARAH E. STOCKMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW #1 & #2
16. SOCIAL SECURITY NO.: 577-18-9758
17. INFORMANT: Mrs. Josephine M. Schaeffer, 9205 2nd Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — Onset and Duration: sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Feb. 24, 1959
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/27/59
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond [illegible]
ADDRESS: SILVER SPRING, MD.
24a. RECORDED BY REGISTRAR: DATE FEB 2 [illegible]
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A 5ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2006 CERTIFICATE OF DEATH

Reg. Dist No.

1 PLACE OF DEATH
a COUNTY [illegible] MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c LENGTH OF STAY IN 1b 7 days
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION [illegible]

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a STATE [illegible]
b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
d STREET ADDRESS [illegible]
e IS RESIDENCE ON A FARM YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Elmer Middle: Ellsworth Last: Schuttle

4 DATE OF DEATH Month: 2 Day: [illegible] Year: 19[illegible]

5 SEX: M
6. COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4-17-99
9 AGE (In years last birthday): 6[illegible] yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Farmer
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Richard Schuttle
14 MOTHER'S MAIDEN NAME: Emma Gillman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17 INFORMANT: Washington Sanitarium Hospital Address: [illegible]

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

		Interval between onset and death
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Cerebral embolism	7 days
DUE TO (b)	Auricular fibrillation	unknown
DUE TO (c)	Arteriosclerotic heart disease	unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Feb 2, 19[illegible] to Feb 9, 19[illegible], that I last saw the deceased alive on Feb 9, 19[illegible], and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE [illegible] M.D.
ADDRESS (Street, city or town, state): Silver Spring, Md.
DATE SIGNED: 2-9-59
PHYSICIAN'S NAME (Type): 927 Pearling Dr.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-12-59
22c NAME OF CEMETERY OR CREMATORY: Glen Haven Cem
22d LOCATION (City, town, or county): Glen Dale, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Home
ADDRESS: 136 G Street
24a. REC'D BY REGISTRAR DATE: FEB 3 [illegible]
24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2143

CERTIFICATE OF DEATH

02123

Reg. Dist. No. 215

PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, (Rural)

c. LENGTH OF STAY IN 1b: 12 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

d. STREET ADDRESS: 12805 Caldwell Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ottice Middle: Roddam Last: SCHEILE

4. DATE OF DEATH: Month: February Day: 10 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-31-13

9. AGE (In years last birthday): 46 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 1 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William SCHEILE

14. MOTHER'S MAIDEN NAME: Alice LANE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1931 to 1958

16. SOCIAL SECURITY NO.: 420-52-5445

17. INFORMANT: (W) Mrs. Dorothy Scheile, Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

and

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (b) Esophageal hemorrhage — 12 days

(c) Cirrhosis, liver, Laennec — 8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 29, 1959 to February 10 1959 that I last saw the deceased alive on February 10, 1959, and that death occurred at 10:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. T. Horgan MD — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-11-59

PHYSICIAN'S NAME (Type): J. T. HORGAN, LCDR, MC, USN — Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-13-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: R. A. Humphrey — ADDRESS: R. A. Humphrey Funeral Home, Bethesda, Md.

24a. RECORDED BY REGISTRAR DATE: FEB 13 59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2144 CERTIFICATE OF DEATH

Reg. Dist. No. 2124

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 12
d. STREET ADDRESS: 1216 Cedarcroft Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: Reinhardt — Last: Schneider, III

4 DATE OF DEATH: Month: February — Day: 11, — Year: 19 59

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: March 19, 1957
9 AGE (In years last birthday): / yrs — IF UNDER 1 YEAR: Months: 22 — Days — IF UNDER 24 HRS.: Hours — Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.
13 FATHER'S NAME: Joseph R. Schneider, Jr.
14 MOTHER'S MAIDEN NAME: Marcia H. Hughes
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO: None
17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute lymphoblastic leukemia
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from January 6, 1959, to February 11, 1959, that I last saw the deceased alive on February 11, 1959, and that death occurred at 3:30p M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Nathan S. Taylor M.D.
PHYSICIAN'S NAME (Type): NATHAN S. TAYLOR, M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2/12/59

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/14/59
22c. NAME OF CEMETERY OR CREMATORY: Mordecai Park
22d. LOCATION (City, town, or county) (State): Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Linard J. Keck
ADDRESS: 530 V Hilford
24a REC'D BY REGISTRAR: DATE FEB 16 59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any [redacted] within 72 hours after death.

VS A35 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

"212"

2145

CERTIFICATE OF DEATH

Reg. Dist No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Ohio
b. COUNTY: Pike
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waverly
d. STREET ADDRESS: Box 175 - RR2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Benton — Middle: VanDyke — Last: SCOTT
4 DATE OF DEATH: Month: February — Day: 16 — Year: 1959
5 SEX: Male
6 COLOR OR RACE: Caucasian
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 2-24-94
9 AGE (In years last birthday): 64 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Doctor of Medicine
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Indiana
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: Charles SCOTT
14 MOTHER'S MAIDEN NAME: Charlette VANDYKE
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWI & WWII
16 SOCIAL SECURITY NO: None
17 INFORMANT: (W) Alice E. Scott, same as #2 above — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)): Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
162.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from December 16, 1959 to February 16, 1959, that I last saw the deceased alive on February 14, 1959, and that death occurred at 4:15 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: J T Horgan M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-16-59
PHYSICIAN'S NAME (Type): J. T. HORGAN, LCDR, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-18-59
22c NAME OF CEMETERY OR CREMATORY: Arlington National
22d LOCATION (City, town or county) (State): Arlington, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: James L. Ives — ADDRESS: Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.
24a RECORDED BY REGISTRAR: DATE FEB 18 '59
24b REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2146 **CERTIFICATE OF DEATH** Reg. Dist. No. 0212

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

7. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Minnesota b. COUNTY: Hennepin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hopkins
d. STREET ADDRESS: 15221 Lynn Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ray Middle Parker Last Sheldon
4. DATE OF DEATH: Month Feb. Day 25 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 17-1886
9. AGE (In years last birthday): 72 yrs
If UNDER 1 YEAR: Months 11 Days 8
If UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railway Equipment Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles F. Sheldon
14. MOTHER'S MAIDEN NAME: Elizabeth Dunning
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service): 712-16-5203 Yes
17. INFORMANT: Son - George Sheldon Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO VASCULAR COLLAPSE — Interval between onset and death: 2 hrs
DUE TO (b) LOBAR PNEUMONIA — 24 hrs
DUE TO (c)
490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 18, 1959 to Feb. 25, 1959, that I last saw the deceased alive on Feb. 25, 1959, and that death occurred at 12 Noon, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert G. Angle MD — ADDRESS (Street, city or town, state): 5009 Del Ray Ave., Bethesda Md — DATE SIGNED: 2/28/59

PHYSICIAN'S NAME (Type): Robert G. Angle 5009 DelRay Ave. Bethesda, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/28/59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE MAR 2 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A 5 (4) 15M 9 '55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2147

Reg Dist No 0212

1 PLACE OF DEATH
a COUNTY Montgomery
b CITY OR TOWN (If outside corporate limits write RURAL) Bethesda
c LENGTH OF STAY IN 1b D.O.A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp

MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a STATE MARYLAND b COUNTY MONTGOMERY
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) SILVER SPRING
d STREET ADDRESS 8600 SUNDALE DRIVE
e Inside city limits? ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First LISA Middle MARILYN Last SHULMAN
4 DATE OF DEATH Month 2 Day 11 Year 1959
5 SEX female
6 COLOR OR RACE white
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH December 28, 1958
9 AGE (Last birthday) 6 weeks IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) D.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Sidney Shulman
14 MOTHER'S MAIDEN NAME Bellin
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT father Address same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Asphyxia
DUE TO
(b) Septic Respiratory Infection
DUE TO
(c)
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH
Found collapsed in baby carriage

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month Day Year
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2-11-59
EXAMINER'S NAME (Type) FRANK J. BROSCHART

22a BURIAL CREMATION REMOVAL (Specify) Burial
22b DATE THEREOF 2/12-1959
22c NAME OF CEMETERY OR CREMATORY Mt. Memorial Park
22d LOCATION (City, town, or county) Falls Church (State) Va

23 FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home
ADDRESS 4279 9th St Washington D.C.
24a RECEIVED BY REGISTRAR DATE FEB 1 [illegible]
24b REGISTRAR'S SIGNATURE [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please exercise the utmost care and write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15MIE
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2007 **CERTIFICATE OF DEATH** Reg. Dist. No. 1212

1 PLACE OF DEATH a. COUNTY [illegible] MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park

c. LENGTH OF STAY IN 1b 10 minutes

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible] Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE [illegible] b. COUNTY [illegible]

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum

d. STREET ADDRESS 1405 Nicholas St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH Month [illegible] Day [illegible] Year 19[illegible]

5 SEX Male 6. COLOR OR RACE [illegible] 7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH [illegible] 19[illegible]

9 AGE (In years last birthday) [illegible] yrs

IF UNDER 1 YEAR: Months [illegible] Days [illegible]

IF UNDER 24 HRS: Hours [illegible] Min [illegible]

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber

10b. KIND OF BUSINESS OR INDUSTRY [illegible]

11 BIRTHPLACE (State or foreign country) Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME [illegible] Smith

14. MOTHER'S MAIDEN NAME [illegible] Dean

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT [illegible] Wife Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs

DUE TO (b) Coronary Artery Heart Disease — 4-5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19[illegible]

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Apr. 29, 1958 to Feb. 3, 1959, that I last saw the deceased alive on Feb. 3, 1959, and that death occurred at 5:35 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE Robert B. Irey M.D. ADDRESS (Street, city or town, state) 7105 Riggs Rd Hyattsville Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Robert B Irey

22a BURIAL, CREMATION, REMOVAL (Specify) [illegible]

22b DATE THEREOF 2/7/59

22c NAME OF CEMETERY OR CREMATORY Ft Lincoln

22d LOCATION (City, town, or county) (State) Colmar Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible]

24a. REC'D BY REGISTRAR DATE FEB 5 '59

24b REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A 5 (4) ISM 9 '55

1

Item 18 Film 241 4-17-59 ams

0212

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2148

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 731 S. Columbus St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Lois — Middle: Kent — Last: SPARKMAN

4 DATE OF DEATH: Month: February — Day: 18 — Year: 1959

5 SEX: Female

6 COLOR OR RACE: Caucasian

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 1-1-87

9 AGE (In years last birthday): 72 yrs — IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: - - - - -

11 BIRTHPLACE (State or foreign country): So. Carolina

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: John G. THATCHER

14 MOTHER'S MAIDEN NAME: Constance E. JOHNSON

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO.: Unknown

17 INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis, [illegible]
DUE TO: Cerebrovascular [illegible]
(b): [illegible]
DUE TO: [illegible]
(c): [illegible]

INTERVAL BETWEEN ONSET AND DEATH: [illegible]

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): [illegible]

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year, Hour, a. m., p. m., 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from February 15, 1959, to February 18, 1959, that I last saw the deceased alive on February 18, 1959, and that death occurred at 3:34A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-18-59

PHYSICIAN'S NAME (Type): J. W. DAVIS, LT, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b DATE THEREOF: 2-20-59

22c NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

22d LOCATION (City, town, or county): Suitland — (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wheatley Funeral Home, 809 King St., Alex., Va.

24a RECORDED BY REGISTRAR: DATE FEB 24 9

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02130

2149

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN 1b: 40 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Virginia
b COUNTY: Prince William
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manassas
d STREET ADDRESS: 237 E. Center Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Grace — Middle: Nevada — Last: Spencer
4 DATE OF DEATH: Month: February — Day: 16, — Year: 1959

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: June 3, 1919
9 AGE (In years last birthday): 39 yrs.
If UNDER 1 YEAR: Months: Days: If UNDER 24 HRS: Hours: Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): West Virginia
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Clive Alderman
14 MOTHER'S MAIDEN NAME: Elsie Dean

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: None
17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rheumatic Heart Disease with involvement of
DUE TO Mitral and Aortic Valves.
Conditions if any which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month: Day: Year: Hour: a. m. p. m. 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from January 7, 1959 to February 16, 1959 that I last saw the deceased alive on February 16, 1959, and that death occurred at 8:34 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edgar Haber M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2-17-59
PHYSICIAN'S NAME (Type): Edgar Haber, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Feb. 20, 1959
22c NAME OF CEMETERY OR CREMATORY: Beaver Creek Cemetery
22d LOCATION (City, town, or county) (State): Huntersville, West Va.

23 FUNERAL DIRECTOR'S SIGNATURE: F. Grecha Sons — ADDRESS: Hyattsville Md.
24a RECD BY REGISTRAR: DATE FEB 20 '59
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached to the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

"213 I

2150 **CERTIFICATE OF DEATH**

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN (b): 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4000 Cathedral Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Albert — Middle: Raymond — Last: STAUDT
4 DATE OF DEATH: Month: February — Day: 9 — Year: 1959
5 SEX: Male
6 COLOR OR RACE: Caucasian
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3-6-96
9 AGE (In years last birthday): 62 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11 BIRTHPLACE (State or foreign country): Ohio
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: John W. A. STAUDT
14 MOTHER'S MAIDEN NAME: May WATTERS
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI & WWII
16 SOCIAL SECURITY NO.: 294-09-8729
17 INFORMANT: (X) Mrs. Alexandra M. Staudt, same as #2 — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: [illegible]
153.8
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from February 7, 1959, to February 9, 1959, that I last saw the deceased alive on February 9, 1959, and that death occurred at 6:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital — DATE SIGNED: 2-9-59

PHYSICIAN'S NAME (Type): A. T. THORP, JR., LT, MC, USN — Bethesda, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-13-59
22c NAME OF CEMETERY OR CREMATORY: Arlington National
22d LOCATION (City, town, or county) (State): Arlington Va.

23 FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Forest Funeral Home, Bethesda, Md.
24a RECD BY REGISTRAR: DATE FEB 1 1 1959
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2132

2151 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 26 days

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: West Virginia b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg

d. STREET ADDRESS: 611½ Stanley Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Pauline Middle: Jackson Last: Strether

4 DATE OF DEATH: Month: February Day: 11, Year: 1959

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: January 6, 1908

9 AGE (In years last birthday): 51 yrs

F. UNDER 1 YEAR: Months: Days: 5

F. UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Ellis A. Bennett

14 MOTHER'S MAIDEN NAME: Estelle Jackson

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-01-0952

17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] Acute Tracheobronchial Obstruction

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) due to Aspirated Blood. — INTERVAL BETWEEN ONSET AND DEATH: Minutes

148 X

DUE TO (b) Acute Hemorrhage from Ruptured Carotid Artery — Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Carcinoma of the Pharynx. — Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS A AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from January 16, 1959, to February 11, 1959, that I last saw the deceased alive on February 11, 1959, and that death occurred at 10:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edgar H. Levin M.D. — ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland — DATE SIGNED: 2-12-59

PHYSICIAN'S NAME (Type): Edgar H. Levin, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2/14/59

22c NAME OF CEMETERY OR CREMATORY: Lumbersport Cemetery

22d LOCATION (City, town, or county) (State): Harrison Co. W. Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a REC'D BY REGISTRAR: DATE: Feb 25 59

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9 '55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2152

CERTIFICATE OF DEATH

Reg. Dist. No. 2133

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 156 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: West Virginia — b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Enterprise

d. STREET ADDRESS: Box 93

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Wilbur — Middle: Riley — Last: Sturm

4 DATE OF DEATH: Month: February — Day: 11, — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 12, 1912

9 AGE (In years on last birthday): 46 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): County Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: County Government

11 BIRTHPLACE (State or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lucius R. Sturm

14 MOTHER'S MAIDEN NAME: Martha Nutter

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16 SOCIAL SECURITY NO.: 235-58-8810

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Respiratory insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO (b): Bronchopneumonia — 12 hrs.

DUE TO (c): Metastatic teratocarcinoma — 14 Mos.

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I attended the deceased from September 8, 1958 to February 11, 1959, that I last saw the deceased alive on February 11, 1959, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. Rose, M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 2-11-59

PHYSICIAN'S NAME (Type): James A. Rose, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/14/59

22c. NAME OF CEMETERY OR CREMATORY: Shinnston Masonic

22d. LOCATION (City, town, or county) (State): Shinnston, W. Va.

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-Bethesda, Maryland

24a. REC'D BY REGISTRAR: DATE

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9-55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2153

Reg Dist No. 12134

1 PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington Gardens Nursing Home
c. LENGTH OF STAY IN (b): 1 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3000 McComas Ave. Silver Spring

MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2829 27th St. N.W.
e. ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward Middle: L. Last: Sturtevant
4. DATE OF DEATH: Month: Feb. Day: 24 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 26, 1875
9. AGE (If years, give birthday): 84 yrs. UNDER 1 YEAR: Months | Days | UNDER 24 H: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steward
10b. KIND OF BUSINESS OR INDUSTRY: Shoreham Hotel
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: E. Lewis Sturtevant
14. MOTHER'S MAIDEN NAME: Mary unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 082-01-5682
17. INFORMANT: Mrs. Miriam H. Douglas, 830 Potomac Plaza, Wash. D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Congestive Heart failure — Interval between onset and death: 3 hrs
DUE TO (b): Chronic cardio-rinal desease — months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Feb. 24, 1959

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL: CREMATION
22b. DATE THEREOF: 2/26/59
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CREMATORY
22d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC.
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR, DATE: FEB 27 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the remaining items in pencil, writing the word "pending" in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Health Officer. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2154 CERTIFICATE OF DEATH

Reg. Dist. No. 02135

1 PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 17 West Kirk Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: M. Last: Stutz
4. DATE OF DEATH: Month: February Day: 16 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 28, 1871
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles M. Robinson
14. MOTHER'S MAIDEN NAME: Anna Rosecroft Vance
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Ben Lohrer—nephew Reading, Pa. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1-wk.
DUE TO (b) Arteriosclerosis
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-[illegible] 1957, to Feb. 16 1959, that I last saw the deceased alive on Feb 16, 1959, and that death occurred at [illegible] P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Fleet Lockett M.D. — ADDRESS (Street, city or town, state): 5006 Kensington Rd. Md. — DATE SIGNED: 2-16-59

PHYSICIAN'S NAME (Type): W. Fleet Lockett — 5006 Kensington Rd. Md. — 2/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/17/59
22c. NAME OF CEMETERY OR CREMATORY: J. Im. Leets Sons Co.
22d. LOCATION (City, town, or county) (State): 3[illegible]-4th St. N.E. Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: Wash. D.C.
24a. REC'D BY REGISTRAR DATE: FEB 18 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No

1 PLACE OF DEATH
a COUNTY: Montgomery
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park
c LENGTH OF STAY IN 1b: 8 hrs
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San and Hosp
MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Md
b COUNTY: Monty
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d STREET ADDRESS: 8809 Glenville Rd
e ON A FARM? YES ☐ NO ☒

3 NAME OF DECEDENT (Type or print): First: Virgia Middle: Lee Surname: Sweeney

4 DATE OF DEATH: Month: Feb Day: 25 Year: 1959

5 SEX: F
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: 7-5-15
9 AGE (In years last birthday): 43 yrs
10 IF UNDER 1 YEAR: Months Days
11 IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): N.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Edward L. Bryson
14 MOTHER'S MAIDEN NAME: Margaret E. Alexander

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: Hosp Record
Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Respiratory failure
DUE TO (b): Barbiturate poisoning
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Interval Between Onset and Death: 12 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Hour a.m. p.m. Month Day Year
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f (City or town, (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Bruschart, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Feb 25-1959

EXAMINER'S NAME (Type): FRANK J. BRUSCHART

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2/28/1959
22c NAME OF CEMETERY OR CREMATORY: National Memorial Park
22d LOCATION (City, town, or county) (State): Falls Church, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co.
ADDRESS: 2901 14th St., N.W. Wash. D.C.
24a REC'D BY REGISTRAR: DATE FEB 27 59
24b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data are necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the relative or other person responsible for burial. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15ME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2155 CERTIFICATE OF DEATH

"2157

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN this place: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4900 Western Avenue

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chevy Chase- Washington 16, D. C.
d. STREET ADDRESS: 4900 Western Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First DAISY Middle LAURA Last TAIT

4 DATE OF DEATH: Month February Day 13, Year 19 59

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: July 2, 1874
9 AGE (In years last birthday): 84 yrs. UNDER 1 YEAR: Months 7 Days 11 UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (State or foreign country): California
12 CITIZEN OF WHAT COUNTRY? U. S.

13 FATHER'S NAME: George Johnson
14. MOTHER'S MAIDEN NAME: Emily Gamage

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. Charles Trussell-same as above — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory failure — INTERVAL BETWEEN ONSET AND DEATH 1 hr
DUE TO (b) Cachexia
DUE TO (c)
Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Generalized arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month Day Year Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from July 1958 to February 13 1959 that I last saw the deceased alive on February 13 1959 and that death occurred at 12:4 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: Elaine W Murphy M.D. — ADDRESS (Street, city or town, state): 4812 Ellicott St NW — DATE SIGNED: 2-13-59

PHYSICIAN'S NAME (Type): Elaine W. Murphy, M.D. 4812 Ellicott St. N. W. Wash. D. C

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/16/59
22c NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d LOCATION (City, town, or county) (State): Washington, D. C.

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 16 59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be delivered to the funeral director. Pages 1 and 2 should be attached for use as the burial transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2009

Reg. Dist. No. 1213

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Maven Sani. Hom

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md. b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING

d. STREET ADDRESS: 724 GIST AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Martha — Middle: A — Last: Taylor

4 DATE OF DEATH: Month: Feb. — Day: 6 — Year: 1959

5 SEX: Female

6. COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: June 2, 1875

9 AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11 BIRTHPLACE (State or foreign country): SHOALS, INDIANA

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: Amos Maitland

14. MOTHER'S MAIDEN NAME: Lavina Hetmen

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 497-22-2160

17 INFORMANT: Miss Jerne Ney — Address: 7515 Carroll Ave. TA. PK.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

493X

DUE TO (b)

Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a): Arteriosclerosis, generalized. Arteriosclerotic heart disease.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1956 to Feb., 1959 that I last saw the deceased alive on January 27, 1959, and that death occurred at 9:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Spruch T. Kimble M.D. — ADDRESS (Street, city or town, state): 929 Pershing Dr., Silver Spring — DATE SIGNED: Feb 6, 1959

PHYSICIAN'S NAME (Type): SPRUCH T. KIMBLE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 2/8/59

22c. NAME OF CEMETERY OR CREMATORY: ALABAM CEMETERY

22d. LOCATION (City, town, or county) (State): MAYTON COUNTY, ARKANSAS

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] FUNERAL, INC. — ADDRESS: SILVER SPRING, MD.

24a REC'D BY REGISTRAR: DATE FEB 9 '59

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2156

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN MARYLAND: 15 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Montg Co Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
d. STREET ADDRESS: X
e. RES ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Otha; Middle: Everman; Last: Thomas
4. DATE OF DEATH: Month 2 Day 20 Year 1959
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-9-96
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mason
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Chas Edw. Thomas
14. MOTHER'S MAIDEN NAME: Martha E. Carter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOC. SEC. NO.
17. INFORMANT: Beatrice Thomas — Address: Sandy Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Hemorrhage
DUE TO
(b) Ruptured dissecting hemorrhage of
DUE TO
(c) Abdominal Aorta
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS A TOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-21-59
EXAMINER'S NAME (Type): FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL: Burial
22b. DATE THEREOF: 2/24/59
22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial,
22d. LOCATION (City, town, or county) (State): Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: DATE FEB 2 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the reverse side by writing the word "pending" in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be returned to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A1SME
SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2157 **CERTIFICATE OF DEATH** Reg. Dist. No. 02140

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b: 3 Months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LeDeau Gardens Nursing Home

d. STREET ADDRESS: 9108 COLUMBIA BLVD.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harriet Middle H. Last Tillson

4. DATE OF DEATH: Month February Day 10 Year 1959

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/4/63

9. AGE (In years last birthday): 96 yrs

If UNDER 1 YEAR: Months Days

If UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now): BAKER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FERDINAND HUBBARD

14. MOTHER'S MAIDEN NAME: MARY OTIS DORCHESTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mr. Marion T. Silkett, 9108 Columbia Blvd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

DUE TO (b) Arteriosclerotic Valvular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 11, 1959 to Feb 9, 1959 that I last saw the deceased alive on Feb 9, 1959 and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 10609 Concord Street DATE SIGNED: Feb 10, 1959

PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D. Kensington, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/16/59

22c. NAME OF CEMETERY OR CREMATORY: ROCKFORD MAUSOLEUM

22d. LOCATION (City, town, or county) (State): ROCKFORD, ILLINOIS

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE FEB 13 '59

24b. REGISTRAR'S SIGNATURE: Cathy L. Hand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2158

CERTIFICATE OF DEATH

00762

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9406 Monroe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Roy — Middle: Oscar — Last: TRAVIS

4 DATE OF DEATH: Month: February — Day: 3 — Year: 1959

5 SEX: Male

6 COLOR OR RACE: Caucasian

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 1-13-97

9 AGE (In years last birthday): 62 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b KIND OF BUSINESS OR INDUSTRY: Construction

11 BIRTHPLACE (State or foreign country): No. Carolina

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: Henry TRAVIS

14 MOTHER'S MAIDEN NAME: Mary HEWITT

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO: 578-07-3436

17 INFORMANT: (SinL) Harvey James Bacon, same as #2 above — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with Metastasis

DUE TO (b)

DUE TO (c)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 3 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS A TOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month — Day — Year — Hour — a.m. p.m. — 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from January 6, 19 59, to February 3, 19 59, that I last saw the deceased alive on February 2, 19 59, and that death occurred at 5:25 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jerome A. Gold, M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-3-59

PHYSICIAN'S NAME (Type): Jerome A. GOLD, LT, MC, USN — Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Spec.): Burial Shipment

22b DATE THEREOF: 2-3-59

22c NAME OF CEMETERY OR CREMATORY

22d LOCATION (City, town, or county): Charlottesville — (State): Va.

23 FUNERAL DIRECTOR'S SIGNATURE: G.H. Hines Co., 2901 14th St., NW, Washington, DC — ADDRESS: 54 5th St. Co.

24a REC'D BY REGISTRAR: DATE FEB 5 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2010

Reg. Dist. No. 2141

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
d. STREET ADDRESS: 2100 Dexter Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Trout
4. DATE OF DEATH: February 6 1957
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/4/57
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months / Days 2 — IF UNDER 24 HRS: Hours 2 / Min 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: NOT GIVEN
14. MOTHER'S MAIDEN NAME: Doria Lyman Trout
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — If yes, give war or dates of service:
16. SOCIAL SECURITY NO.:
17. INFORMANT: sister — Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Hemorrhage - gastrointestinal
DUE TO
(b) Prematurity
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/4/57, 19 to 2/6/57, 19 57 that I last saw the deceased alive on 2/6/57, 1957, and that death occurred at 8:5 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George R. Spence M.D. — ADDRESS (Street, city or town, state): 927 Persoing Dr., Silver Spring, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): George R. Spence, M. D. — 927 Pershing Dr., Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2-28-59
22c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hosp.
22d. LOCATION (City, town, or county) (State): Takoma Park, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Hare, M. D. Washington Sanitarium and Hosp. Takoma Park, Maryland
24a. RECORD BY REGISTRAR
24b. REGISTRAR'S SIGNATURE
DATE: MAR 3 '59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and deliver the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

not contact mother re this death
certificate

William H. Hyatt

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2011 CERTIFICATE OF DEATH

Reg. Dist. No. 12142

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
c. LENGTH OF STAY IN (b): 18 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 8857 Carlans Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest; Middle: Charles; Last: Upchurch
4. DATE OF DEATH: Month: Feb.; Day: 8; Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-29-05
9. AGE (In years last birthday): [illegible] yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teamster
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: Lewis H. Upchurch
14. MOTHER'S MAIDEN NAME: Rader Howell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO (b) Hypertensive Heart Disease — 10 yr
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-15-59, 19__, to 2-8-59, 19__, that I last saw the deceased alive on 2-8-59, 19__, and that death occurred at 9:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D.
PHYSICIAN'S NAME (Type): [illegible]
ADDRESS (Street, city or town, state): 931 Ellsworth Dr. Silver Spring, Md.
DATE SIGNED: 2-8-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/9/59
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: S. H. Omer Co.
ADDRESS: 2901-14th St. N.W.
24a. REC'D BY REGISTRAR: DATE FEB 10 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS ATS (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2159 CERTIFICATE OF DEATH

Reg. Dist. No. 02143

1 PLACE OF DEATH
a COUNTY [illegible] MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c LENGTH OF STAY IN (b) 12 [illegible]
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9408 FLORIDA AVENUE

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE MARYLAND b COUNTY MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d STREET ADDRESS 9408 FLORIDA AVENUE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JAMES Middle EDWARD Last VOGTS, SR.
4 DATE OF DEATH: Month FEBRUARY Day 16 Year 1959
5 SEX MALE
6 COLOR OR RACE WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH Aug. 26, 1894
9 AGE (In years last birthday) 64 yrs
UNDER 1 YEAR: Months Days; UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b KIND OF BUSINESS OR INDUSTRY Self-employed
11 BIRTHPLACE (State or foreign country) MARYLAND
12 CITIZEN OF WHAT COUNTRY U.S.A.
13 FATHER'S NAME ANTON HENRY VOGTS
14. MOTHER'S MAIDEN NAME Eliza MONTGOMERY
15 WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service)
16 SOCIAL SECURITY NO. 577-03-3386
17 INFORMANT Mrs. Minnie C. Vogts, 9408 Florida Ave. Silver Spring, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis syndrome — INTERVAL BETWEEN ONSET AND DEATH 2 weeks
DUE TO (b) Heart Block (Complete)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
433.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS A TOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from [illegible] 1957 to [illegible] 1959 that I last saw the deceased alive on [illegible] 1959 and that death occurred at [illegible] P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED [illegible]

PHYSICIAN'S NAME (Type) William D. Aud, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify) [illegible]
22b DATE THEREOF 2/18/59
22c NAME OF CEMETERY OR CREMATORY [illegible]
22d LOCATION (City, town, or county) [illegible] (State) [illegible]

23 FUNERAL DIRECTOR'S SIGNATURE Raymond A. [illegible] ADDRESS [illegible]
24a. REC'D BY REGISTRAR DATE FEB 1 [illegible]
24b REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, or cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1 SM 10-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2160 CERTIFICATE OF DEATH

Reg. Dist. No. 02144

1 PLACE OF DEATH a. COUNTY: Prince Geo MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE: Md b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b: 3 mo

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS: 820 University Blvd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Ella (First) Frances (Middle) Walker (Last)

4. DATE OF DEATH: Feb (Month) 21 (Day) 1959 (Year)

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 18 1875

9. AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: George Grossl

14. MOTHER'S MAIDEN NAME: Rheta (?) Calvert Co.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Fema Walker Address: 933 - 52th St NE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): High blood pressure — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 20, 1959, to Feb 21, 1959, that I last saw the deceased alive on Feb 21, 1959, and that death occurred at 2:05 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. S. Hudson, M.D. ADDRESS (Street, city or town, state): 509 Rhode Island, N.W. DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur.

22b. DATE THEREOF: Feb. 24, 59

22c. NAME OF CEMETERY OR CREMATORY: Browns

22d. LOCATION (City, town, or county): Port Republic (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: P. E. Sewell Prince Fred. ADDRESS:

24a. REC'D BY REGISTRAR: DATE: Feb 26 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

FOR STATE HEALTH DEPT.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2161

Reg Dist No 02145

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Echo Hts
c. LENGTH OF STAY IN 1b: 9 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 5102 Wehawken Rd., Wash. 16 DC

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission):
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): x Glen Echo Hts.
d. STREET ADDRESS: 5102 Wehawken Rd, Wash 16 DC
INSIDE CORPORATE LIMITS? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Albert; Middle: Aloysius; Last: Ward
4 DATE OF DEATH: Month: Feb; Day: 26; Year: 1959
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 2-16-1907
9 AGE (In years last birthday): 52 yrs
10 IF UNDER 1 YEAR: Months / Days / Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b KIND OF BUSINESS OR INDUSTRY: Auto
11 BIRTHPLACE (State or foreign country): DC
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James G. Ward
14 MOTHER'S MAIDEN NAME: Jeanette Barron
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII
16 SOCIAL SECURITY NO: 528-05-2447
17 INFORMANT: Catherine Ward (wife) Address: Glen E

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, inspection ☒, inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brueckert, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BRUECKERT
DATE SIGNED: 2-26-59

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-28-59
22c NAME OF CEMETERY OR CREMATORY
22d LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
24a REC'D BY REGISTRAR: DATE
24b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the Site Board of Health or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A1SME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2162

CERTIFICATE OF DEATH

Reg. Dist. No. 0214

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 45 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 416 North Horners Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Connie Middle Ellen Last Waters
4. DATE OF DEATH: Month 2 Day 24 Year 1957
5. SEX: Female
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 12 1914
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Shelton
14. MOTHER'S MAIDEN NAME: Maggie M. Wood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Thomas Henry Lee Waters — Address: Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
(b): Coronary thrombosis — 2 hrs.
DUE TO
(c): Coronary A.S. — unk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis, nutritional, of liver, moderate
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month Day Year Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1 1953, to 2/24/57, 19 57, that I last saw the deceased alive on 2/22/57, 19 57, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. ADDRESS (Street, city or town, state): Rockville, Md. DATE SIGNED: 2/27/57
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/1/57
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Park,
22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR
DATE: [illegible]
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician on [illegible]
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2163

CERTIFICATE OF DEATH

2147

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 43 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church
d. STREET ADDRESS: 922 Dashiell Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Cornelius — Last: WATSON
4. DATE OF DEATH: Month: February — Day: 10 — Year: 19 59
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-25-90
9. AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor Foreman
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Govt.
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William WATSON
14. MOTHER'S MAIDEN NAME: Margaret HANNON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (w) Mrs. Margaret Watson, Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchogenic carcinoma left
DUE TO (b): metastases — 1yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 29, 19 58 to February 10, 19 59, that I last saw the deceased alive on February 10, 19 59, and that death occurred at 11:[illegible] AM, from the causes and on the date stated above

ACTUAL SIGNATURE: Douglas R. Koch M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC — DATE SIGNED: 2-11-59

PHYSICIAN'S NAME (Type): Douglas R. KOCH, LT, MC, USN — Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-13-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: W. W. CHAMBLIS FUNERAL HOME, 517 11th St. SE, Wash. D.C.

24a. RECEIVED BY REGISTRAR: DATE FEB 13 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00957

CERTIFICATE OF DEATH

2164

Reg. Dist No. 215

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN (b): 20 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

7 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton

d. STREET ADDRESS: 11510 Highview Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Paul Middle: Richard Last: WEBB

4 DATE OF DEATH: Month: February Day: 2 Year: 1959

5 SEX: Male

6 COLOR OR RACE: Caucasian

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 4-4-84

9 AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Food Broker

10b. KIND OF BUSINESS OR INDUSTRY: Merchandising

11 BIRTHPLACE (State or foreign country): New York

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: Patrick R. Webb

14 MOTHER'S MAIDEN NAME: Jennie Fox

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: 106-05-6178

17 INFORMANT: (S) John J. WEBB, same as #2 above Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) [illegible]

DUE TO (b) [illegible]

DUE TO (c)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I attended the deceased from January 13, 1959, to February 2, 1959, that I last saw the deceased alive on February 2, 1959, and that death occurred at 7:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): U. S. Naval Hospital, NNMC DATE SIGNED: 2-2-59

PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment

22b. DATE THEREOF: 2-3-59

22c. NAME OF CEMETERY OR CREMATORY: Mr. Olivet

22d. LOCATION (City, town, or county): Buffalo (State): New York

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: S. H. HINES CO., 2901 14th St.NW, Washington, DC

24a. REC'D BY REGISTRAR DATE: FEB 3 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete y filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A35 (4) 15M 10-57

1

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A1S (4)
15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2012

0214

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 15 mo
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission.)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 5504 University Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Meyer; Middle: Elias; Last: Weiner
4. DATE OF DEATH: Month: 3; Day: 19; Year: 1954
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 4, 1891
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Fruit Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Morris Weiner
14. MOTHER'S MAIDEN NAME: Paul
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 579-32-2813
17. INFORMANT: Washington Sanitarium Hosp. Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Acute Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
(b) Acute myocardial infarction — 2 hrs.
DUE TO
(c) Arteriosclerosis — 10 yrs.

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1953 to Feb. 1954 that I last saw the deceased alive on Feb. 15, 1954 and that death occurred at 6 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Latten M.D. — ADDRESS (Street, city or town, state): 5244 Colesville Rd. — DATE SIGNED: 2-17-54

PHYSICIAN'S NAME (Type): RALPH F. LATTEN — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/22/1954
22c. NAME OF CEMETERY OR CREMATORY: Geo. Wash. Memorial Park
22d. LOCATION (City, town, or county): Rockville (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Gatchell Funeral Home — ADDRESS: 4217 Georgia Ave. N.W.
24a. REC'D BY REGISTRAR: DATE
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2165

Reg. Dist. No. 02141

1 PLACE OF DEATH
a COUNTY: [illegible] MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
c LENGTH OF STAY IN Ib: [illegible]
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: [illegible]

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: [illegible]
b COUNTY: [illegible]
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
d STREET ADDRESS: [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last [illegible]

4 DATE OF DEATH: Month [illegible] Day [illegible] Year 19[illegible]

5. SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: [illegible]
9 AGE (In years last birthday): [illegible] yrs
IF UNDER 1 YEAR: Months [illegible] Days [illegible]
IF UNDER 24 HRS: Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY: Sol. [illegible]
11 BIRTHPLACE (State or foreign country): [illegible]
12 CITIZEN OF WHAT COUNTRY? [illegible]

13 FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): [illegible] (If yes, give war or dates of service): [illegible]
16. SOC. AL SECURITY NO: [illegible]
17 INFORMANT: [illegible] Address: [illegible]

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Pulmonary Tuberculosis
DUE TO
(b) Tuberculosis
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: [illegible] 2.

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 7/20/ 19[illegible] to 2/21/ 19[illegible], that I last saw the deceased alive on 2/16/ 19[illegible], and that death occurred at [illegible] A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 2/21/57

PHYSICIAN'S NAME (Type): [illegible]

22a BURIAL, CREMATION, REMOVAL (Specify): [illegible]
22b DATE THEREOF: [illegible]
22c NAME OF CEMETERY OR CREMATORY: [illegible]
22d LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible]
24a REC'D BY REGISTRAR: [illegible] DATE: [illegible]
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
TSM 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No 92150

2017

1 PLACE OF DEATH
a COUNTY
MARYLAND
b. CITY OR TOWN (outside corporate limits, write RURAL and give nearest town)
c LENGTH OF STAY IN (b)
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

7 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE
b COUNTY
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
d STREET ADDRESS
INSIDE CORPORATE LIMITS YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Elisabeth Middle R. Last
4 DATE OF DEATH Month Day Year 19
5 SEX
6 COLOR OR RACE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH
9 AGE (in years last birthday)
IF UNDER YEAR Months Days
IF UNDER 24 HR Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country)
12 CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME
14 MOTHER'S MAIDEN NAME Edith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) No
16 SOCIAL SECURITY NO
17 INFORMANT Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)
DUE TO
(b) Hanging
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) County State

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐, Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Buechart
EXAMINER'S NAME (Type) M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2/12/1959

22a BURIAL CREMATION REMOVAL (Specify) Bur-transit
22b. DATE THEREOF 2/14/59
22c NAME OF CEMETERY OR CREMATORY South Laurel Hill
22d LOCATION (City, town or county) Philadelphia (State) Pennsylvania
23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md
24a. RECD BY REGISTRAR DATE FEB
24b REGISTRAR'S SIGNATURE

TO DEPUTY MED CAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the remainder by writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be attached to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death.

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5M 7 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2166 **CERTIFICATE OF DEATH** 0215

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase

c LENGTH OF STAY IN 1b

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3211 Thornapple Street

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery

c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Chevy Chase

d STREET ADDRESS 3211 Thornapple Street

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Laura Middle Mansur Last Wight

4 DATE OF DEATH Month Feb. Day 23 Year 19 59

5 SEX female

6 COLOR OR RACE white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH 6/22/1863

9 AGE (In years last birthday) 95 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) Maine

12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME Morriall Mansur

14 MOTHER'S MAIDEN NAME Iantha Walker

15 WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT Mildred W. Syfrig Address 3211 Thornapple St. Chevy Chase, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart failure — 1 month

434.1

DUE TO (b) Advanced age

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sub-acute Cholecystitis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month Day Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Jan. 19 55 to Feb 23 19 59 that I last saw the deceased alive on Feb 23 19 59, and that death occurred at 8 30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE John V Dolan MD ADDRESS (Street, city or town, state) 3106 Conn. Ave DATE SIGNED 2/23/59

PHYSICIAN'S NAME (Type) John V. Dolan

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 2/26/59

22c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery

22d LOCATION (City, town, or county) (State) Prince Georges County, Md.

23 FUNERAL DIRECTOR'S SIGNATURE Geo. H. Hines Co ADDRESS 2904-14th St. NW Wash 9 DC

24a REC'D BY REGISTRAR DATE FEB 2 [illegible]

24b REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2013

Reg. Dist. No. 02152

1 PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Takoma Park

c. LENGTH OF STAY IN this place: 14yr. 2mo.

d. NAME OF HOSPITAL (If not in hospital, give street address or INSTITUTION): OAK HAVEN REST HOME

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.

d. STREET ADDRESS: 4220 Van Ness St., N.W. Washington DC

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): Della Hoover Wilber

4 DATE OF DEATH: Feb. 15 1959

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Sept. 18, 1869

9 AGE (in years last birthday): 89 yrs.

If UNDER 1 YEAR or UNDER 24 HRS: Months | Days | Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Staunton, Virginia

12 CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William Hoover

14 MOTHER'S MAIDEN NAME: Mary Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: None

17 INFORMANT: Janet Edith Wilber M.D. Address: 4250 Van Ness St. NW

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): pneumonia hypostatic — Dec. 30, 1958

DUE TO (c): Repeated colds

470

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Advanced Age.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): None

20c TIME OF INJURY: Hour a.m. p.m. Month Day Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Dec. 30, 1958 to Feb. 15, 1959, that I last saw the deceased alive on Feb. 13, 1959, and that death occurred at 1 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis K. Alpert MD — ADDRESS (Street, city or town, state): 2300 K St. N.W. — DATE SIGNED: 2/15/59

PHYSICIAN'S NAME (Type): Louis K. Alpert 2300 K St. N.W. Washington, D.C.

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b DATE THEREOF: 2/16/59.

22c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d LOCATION (City, town or county) (State): Suitland Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Chas. Chas. Funeral Home — ADDRESS: 3102 Wisconsin Ave. Washington D.C.

24a REC'D BY REGISTRAR: DATE FEB 1 6 59

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A 5 (4) 15M 9 '55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2014 CERTIFICATE OF DEATH

Reg Dist No. 2153

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c LENGTH OF STAY IN this place: 61 minutes
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Washington Sanitarium

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland
b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring,
d STREET ADDRESS: 1714 Gridley Lane,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Infant Boy; Middle: ; Last: Wilson
4 DATE OF DEATH: Month 2, Day 9, Year 1959
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 2-9-59
9 AGE (In years last birthday): yrs; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours 1, Min 1
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Reynolds Wilson, Jr
14. MOTHER'S MAIDEN NAME: Mary Jane Shanks
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: Mother's Sister — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH: 1 hour & 1 min.
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m.
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from _____ 19____, to _____ 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Valgene M. Milstead, M.D. ADDRESS (Street, city or town, state): 925 Pershing Dr. Silver Spring, Md. DATE SIGNED: 2/9/59
PHYSICIAN'S NAME (Type): Valgene M. Milstead, M. D. 925 Pershing Dr., Silver Spring, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b DATE THEREOF: 2-10-59
22c NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hosp.
22d LOCATION (City, town, or county) (State): Takoma Park, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D.
ADDRESS: Washington Sanitarium and Hosp. Takoma Park, Md.
24a. REC'D BY REGISTRAR: Feb 13
DATE:
24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10.57

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 2 imG238 2-11-59 et

Date of Film and Item Numbers

CERTIFICATE OF DEATH

2167

Reg. Dist. No. 02151

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda, Md

c. LENGTH OF STAY IN 16: 3 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If not usual residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg

d. STREET ADDRESS: Route # 3.

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Mary Middle: Ann Last: Wilson

4 DATE OF DEATH: Month: February Day: 1 Year: 1959

5 SEX: Female

6 COLOR OR RACE: Colored

7 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8 DATE OF BIRTH: Sept. 16, 1941

9 AGE (In years last birthday): 17 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Moses F. Wilson

14 MOTHER'S MAIDEN NAME: Mary Ann Twyman.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17 INFORMANT: Mary Ann Wilson (mother) Address: Gaithersburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Septicemia, Puerperal, Abortion

681X

DUE TO (b): Streptococcus Hemolyticus Septicemia

DUE TO (c): Acute Streptococcal Endometritis (Puerperal)

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c TIME OF INJURY: Hour a.m. p.m. Month Day Year 19

20d INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from JAN 29, 1959 to FEB 1, 1959, that I last saw the deceased alive on FEB 1, 1959, and that death occurred at 1:15 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Thomas M Wilson, M.D. ADDRESS (Street, city or town, state): 8218 Wisconsin Ave, Bethesda, Md DATE SIGNED

PHYSICIAN'S NAME (Type): THOMAS M WILSON

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 2/5/1959

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Park.

22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hurt L. Snowden ADDRESS: Rockville, Md.

24a REC'D BY REGISTRAR DATE: Feb

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2168 **CERTIFICATE OF DEATH** Reg. Dist. No. 02155

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Germantown
d. STREET ADDRESS: R.F.D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Elizabeth Last: Woodfield
4. DATE OF DEATH: Month: February Day: 25, Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: November 30, 1940
9. AGE (In years last birthday): 18 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Student)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13. FATHER'S NAME: John G. Woodfield
14. MOTHER'S MAIDEN NAME: Elizabeth Zimmerman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

705.4

DUE TO (b) Systemic Lupus Erythematosis — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 27, 1959, to February 25 1959, that I last saw the deceased alive on February 25, 1959, and that death occurred at 12:22 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Brooks M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 2-25-59
PHYSICIAN'S NAME (Type): Charles F. Brooks, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 27, 1959
22c. NAME OF CEMETERY OR CREMATORY: Upper Seneca Baptist
22d. LOCATION (City, town, or county) (State): Cedar Grove, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Wolsworth ADDRESS: Damascus, Md.
24a. REC'D BY REGISTRAR DATE: MAR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) 1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2169

CERTIFICATE OF DEATH

Reg. Dist. No. 02156

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 17 yrs. 8 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Asbury Methodist Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenelg 13-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma Virgina; Middle; Last Wright
4. DATE OF DEATH: Month February; Day 28; Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 21, 1870
9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months 7; Days 7; IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Howard Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Albert Wright
14. MOTHER'S MAIDEN NAME: Margaret Almira Stansfield
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH

493.x

DUE TO (b) Pneumonia — 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-7, 1957, to 2-28, 1959, that I last saw the deceased alive on 2-28, 1959, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sarah E Glover M.D. ADDRESS (Street, city or town, state): 10128 CEDAR LANE KENSINGTON, md DATE SIGNED: 2-28-59

PHYSICIAN'S NAME (Type): Sarah E. Glover, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-3-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. View
22d. LOCATION (City, town, or county) (State): Glenelg, Howard Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Partner, Gaithersburg, Md. ADDRESS:
24a. REC'D BY REGISTRAR DATE: MAR 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57